STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

TENNESSEE STATE VETERANS' HOMES BOARD

Performance Audit Report

October 2018

Justin P. Wilson, Comptroller

Division of State Audit

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TENNESSEE COMPTROLLER OF THE TREASURY

JUSTIN P. WILSON
Comptroller

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Chief of Staff

October 31, 2018

The Honorable Randy McNally
Speaker of the Senate
The Honorable Beth Harwell
Speaker of the House of Representatives
The Honorable Mike Bell, Chair
Senate Committee on Government Operations
The Honorable Jeremy Faison, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

and
Mr. Richard Grant, Chair
Tennessee State Veterans' Homes Board
6498 River Fall Dr.
Memphis, Tennessee 38120
and
Mr. Ed Harries, Executive Director
Tennessee State Veterans' Homes Board
345 Compton Rd.
Murfreesboro, Tennessee 37129

Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Tennessee State Veterans' Homes Board for the period January 1, 2015, through June 30, 2018. This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, *Tennessee Code Annotated*.

Our audit disclosed certain findings, which are detailed in the Audit Conclusions section of this report. The homes' management has responded to the audit findings; we have included the responses following each finding. We will follow up the audit to examine the application of the procedures instituted because of the audit findings.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the Tennessee State Veterans' Homes Board should be continued, restructured, or terminated.

Sincerely,

Deborah V. Loveless

Deborah V. Loveless, CPA
Director

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18/017

Division of State Audit

Tennessee State Veterans' Homes Board
Performance Audit
October 2018

Our mission is to make government work better.

AUDIT HIGHLIGHTS

The central purpose and role of the Tennessee State Veterans' Homes Board is to

- **Provide quality of care and quality of life for our veterans.**
- **Rehabilitate residents to the maximum attainable level of independent functioning by utilizing all necessary governmental and community services and therapies, and to provide a comfortable, safe, sanitary environment conducive to personal happiness.**
- **Make available to residents, social and cultural activities of personal interest designed to foster feelings of dignity and self-respect.**
- **Meet the individual needs of each resident to the greatest extent possible.**

We have audited the Tennessee State Veterans' Homes Board for the period January 1, 2015, through June 30, 2018. Our audit scope included a review of internal controls and compliance with laws, regulations, policies, procedures, and provisions of contracts in the following areas:

- Resident Care;
- Quality Control;
- Human Resources;
- Resident Admissions;
- General Administration; and
- the Board of Directors.

Scheduled Termination Date:
June 30, 2019

We also identified the board's achievements during our audit period.

KEY CONCLUSIONS

FINDINGS

1. While overall federal ratings remained high during our audit period, three of the four veterans' homes received below-average scores in Quality of Resident Care (page 17).
2. The Tennessee State Veterans' Homes executive management did not have adequate internal controls in place over the resident assessment processes and monitoring of contracted direct care providers (page 25).
3. Nurses did not document that they had distributed all doses of medicine to residents as prescribed (page 35).
4. The homes' management did not ensure resident deaths were reported timely and accurately (page 40).
5. The veterans' homes did not ensure that their Quality Assurance Committees and subcommittees fulfilled their responsibilities and duties to help improve operations (page 45).
6. The homes did not have comprehensive policies in place for documenting, addressing, and monitoring the resolutions of complaints received from residents and employees (page 50).
7. The veterans' homes did not document the presence of a Registered Nurse on staff at all times (page 56).
8. The homes' management still did not properly monitor contractors that provide services to residents for compliance with Title VI requirements (page 57).
9. The veterans' homes did not perform the following checks on all employees, including those providing direct care to veterans: criminal background, abuse registry, sex offender registry, drug screening, tuberculosis, and reference (page 59).
10. The veterans' homes lacked internal controls over volunteers (page 64).
11. Management did not ensure that the wait list at each of the four veterans' homes contained required information and that the lists were updated in accordance with established policies and procedures (page 74).
12. Management did not notify the Comptroller's Office of possible unlawful conduct in a reasonable amount of time, as required by state statute (page 80).

Ongoing Investigation

The Comptroller's Office is conducting an investigation into some provider billing and assessment allegations. We will issue a separate report regarding the results of this investigation.

OBSERVATIONS

The following topics are included in this report because of their effect on the operations of the Tennessee State Veterans' Homes Board and the citizens of Tennessee:

- the veterans' homes communicate federal quality of life and quality of care standards through internal policies (page 16);
- the board and management should continue to seek ways to reduce the turnover of staff who provide direct care (page 67);
- veterans' homes board policy lacks specific requirements for establishing Tennessee residency (page 76);
- while the homes did not completely correct the prior emergency preparedness finding, they have achieved federal compliance due to the generalization of regulations (page 82);
- the board did not designate space on its Conflict-of-Interest Policy acknowledgment statement for the disclosure of actual or potential conflicts and did not annually obtain signed statements from all members (page 86);
- the board needs to improve some aspects of its meetings (page 88); and
- the board has recently opened one home and has plans to open three additional homes (page 92).

MATTER FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider defining the eligibility requirements to establish Tennessee residency for admissions into our state veterans' homes, including but not limited to whether an individual can establish residency through a long stay in a Tennessee hospital (page 78).

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

TABLE OF CONTENTS (continued)

INTRODUCTION

AUDIT AUTHORITY

This performance audit of the Tennessee State Veterans' Homes Board was conducted pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated*. Under Section 4-29-240, the board is scheduled to terminate June 30, 2019. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether the Tennessee State Veterans' Homes Board should be continued, restructured, or terminated.

TENNESSEE STATE VETERANS' HOMES BOARD
"Proudly Serving Those Who Served"

BACKGROUND

In 1985, with long-term care as a priority, the Tennessee Department of Veterans Affairs (now Veterans Services) recommended establishing a system of state veterans' homes. In response, the General Assembly created the Tennessee State Veterans' Homes through Chapter 899 of the 1988 Public Acts, codified as Section 58-7-101 et seq., *Tennessee Code Annotated*, with the primary purpose to "provide support and care for honorably discharged veterans who served in the United States armed forces." The U.S. Department of Veterans Affairs promotes the care and treatment of veterans in state veterans' homes as one means to achieve the goal of developing and maintaining quality patient care with an appropriate scope of services to meet the eligible veterans' health care needs.

U.S. Department of Veterans Affairs

The Tennessee State Veterans' Homes operate four skilled nursing facilities across the state, with an Executive Office in Murfreesboro. The Tennessee State Veterans' Homes Board governs the facilities. For further information about the vision of the homes and the homes board, see **Figure 1**.

Figure 1
Vision of the Tennessee State Veterans' Homes and Board

> All residents are cared for in such a manner and in such an environment as to promote enhancement of their quality of life without abridging the safety and rights of other residents. An interdisciplinary team approach to resident life is utilized to assure the quality of life. Residents and family members are involved in the care planning process and resident participation is encouraged through a functioning resident council. Residents' rights are posted and enforced as delineated in current federal and state standards.

Source: Tennessee State Veterans' Homes Board annual report for fiscal year 2017.

BOARD OF DIRECTORS

In accordance with state law, the Tennessee State Veterans' Homes Board must consist of 13 members:

- The Commissioners of the Department of Finance and Administration and the Department of Veterans Services each serve as ex-officio voting members of the board.
- The remaining members are appointed by the Governor and must be Tennessee citizens.
    - At least three of the appointed members must be from each of the state's three grand divisions.
    - One member must be a nursing home administrator at the time of appointment and must have experience in the financial operations of nursing homes.
    - Another member must have clinical experience in nursing homes.
    - All other members must be honorably discharged veterans of the U.S. Armed Forces.

The board features an Executive Committee that includes the Commissioner of the Department of Finance and Administration; a member who was either an administrator of a nursing home when appointed or who has clinical experience in nursing homes; and the chair of the board. The Executive Committee oversees the day-to-day management and operations of the veterans' homes.

Furthermore, the board has established an Audit Committee to foster adherence to and encourage continuous improvement of the board's policies, procedures, and practices.

EXECUTIVE MANAGEMENT

The Tennessee State Veterans' Homes Board organizational chart is on page 8.

Hired by the board, the **Executive Director** guides, directs, and provides oversight for the Executive Office and the homes' operations. The Executive Director is responsible for strategic planning and development, as well as fiscal and

clinical oversight, and reports regularly to the Executive Committee. The Executive Director also hires and supervises the remaining members of executive management:

- An **Administrator** heads each of the homes to establish and maintain effective and efficient systems to operate the home in a financially sound manner and safely meet residents' needs in compliance with federal, state, and local requirements.

- Medical services are provided under the direction of a **Medical Director,** who is a physician licensed to practice medicine in the State of Tennessee. Under policies and procedures approved by the director, the staff meets all residents' medical needs and arranges for any necessary specialty services.

- The **Director of Construction and Facility Management** is responsible for ensuring that the homes meet all applicable laws and regulations, overseeing each aspect of all construction projects, and directing members of maintenance staff from hiring to job performance. The director is further responsible for the upkeep and maintenance of all facilities.

- The **Marketing and Public Relations Manager** supervises marketing, advertising, and event-planning activities at the homes. This manager takes steps to represent, measure, enhance, and enrich the position and image of the homes through various goals and objectives.

- The **Financial Compliance Officer** works with management to ensure a system is in place to provide assurance that all major risks are identified and analyzed on an annual and ongoing basis. The officer reviews transactions and systems for compliance with policies, procedures, statutes, contract terms and conditions, and various supplementary criteria. The officer may conduct reviews and perform other tasks as requested by individual board members, the board's Audit Committee, the homes' Executive Director, or the homes' Finance Director.

- The **Director of Clinical Services** identifies regulatory concerns throughout the facilities and monitors facility compliance with applicable laws and regulations. Additionally, the director is responsible for reporting safety hazards and analyzing charts and patient data for trends.

- The **Director of Clinical Reimbursement** monitors resident assessment staff for process compliance and accuracy, in addition to auditing medical records to assure billing validation.

- The **Finance Director** is responsible for overseeing cash disbursements, payroll closing, and accounting functions. The director also creates and maintains the annual budget, ensures timely and accurate financial reports, and serves as a liaison to external auditors.

- The **Information Technology Director** oversees configuring and maintaining servers, workstations, networks, applications, and security for the homes. Other job duties include maintaining accounting and financial controls, as well as creating and testing backup data recovery systems.

- The **Director of Risk Management** updates contracts, works with staff for contract needs, and drafts policies to adhere to state and local regulations. Moreover, the director is responsible for training staff, responding to employee complaints, overseeing claims filed against the homes, and implementing the Title VI plan.

OPERATING LOCATIONS

Current Homes

Tennessee operates four veterans' homes located across the state. Each home provides both intermediate and long-term care (see **Table 1**).

Table 1
Home Descriptions

Location	Name	Opening Date	Number of Beds	Physical Dimensions*
Murfreesboro**	Tennessee State Veterans' Home	June 1991	140	69,278 square feet
Humboldt	W.D. "Bill" Manning Tennessee State Veterans' Home	February 1996	140	74,870 square feet
Knoxville	Senator Ben Atchley Tennessee State Veterans' Home	December 2006	140	73,065 square feet
Clarksville	Brigadier General Wendell H. Gilbert Tennessee State Veterans' Home	December 2015	108	102,688 square feet
* All one-story buildings.				
** The Murfreesboro home is adjacent to the U.S. Department of Veterans Affairs Alvin C. York Medical Center.				

Source: Tennessee State Veterans' Homes Board annual report for fiscal year 2017.

Figure 2
Home Pictures

Murfreesboro

Humboldt

Knoxville

Clarksville

Source: Auditor photographs.

Home Atmosphere

All four Tennessee State Veterans' Homes were built with the idea of being a "home," not an institution. Home features include libraries with computer and internet access for the residents, private dining rooms for family functions, and multiple lounges and game areas. With the exception of Clarksville, each home has a special needs unit surrounding a landscaped courtyard.

Source: Auditor photograph of lounge at Humboldt home.

Resident Activities

Residents may participate in a wide range of activities designed to increase physical, emotional, and social health. Regular activities include cards, board games, computer games, baking, exercise, gardening, and bird watching. Additionally, the homes offer off-campus trips and host special events, as shown in **Figure 3**.

Figure 3
Resident Activity Pictures

Murfreesboro Air Show

Humboldt Art Class

Knoxville Navy Ball

Clarksville Halloween

Source: Photographs used by permission of management (release dated June 21, 2018).

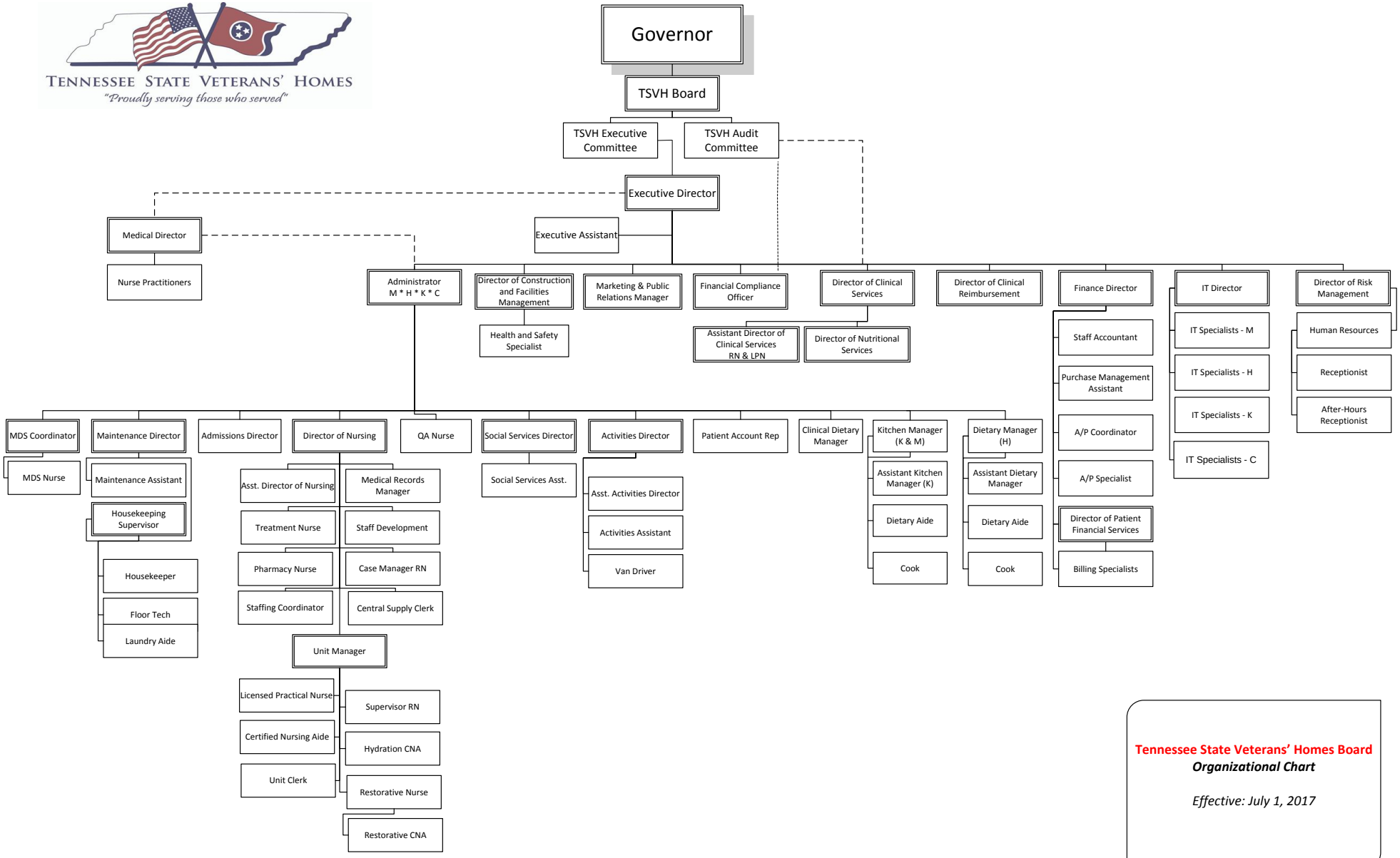
Future Homes

In the upcoming years, the state plans to coordinate with the U.S. Department of Veterans Affairs to build additional homes in Bradley, Shelby, and Sullivan Counties. We present more details in Observation 7.

FINANCIAL STATUS

Section 58-7-111, *Tennessee Code Annotated*, requires the Office of the Comptroller of the Treasury to annually audit the Tennessee State Veterans' Homes "as part of the comptroller's annual audit plan pursuant to § 9-3-211." Section 9-3-211 refers to an "annual audit of financial records and transactions." Our office conducted the homes' financial statement audit for the fiscal years ended June 30, 2015, through June 30, 2017. See https://www.comptroller.tn.gov/sa/SAsub.asp?SC=AG&F= for the financial statement audit reports.

TENNESSEE STATE VETERANS' HOMES
"Proudly serving those who served"



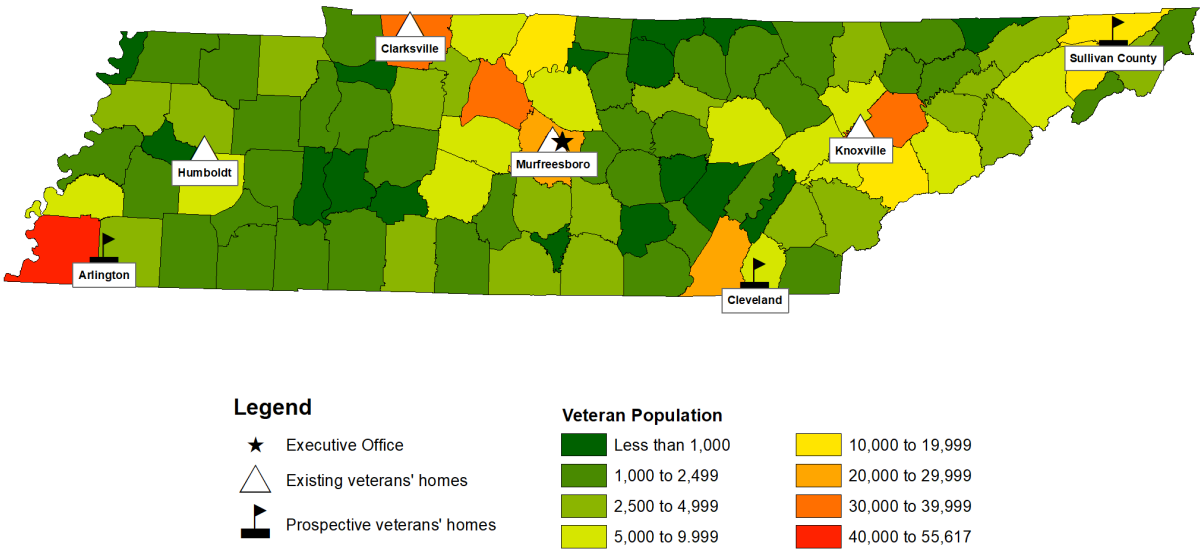
Tennessee State Veterans' Homes Board
Organizational Chart

Effective: July 1, 2017

U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics
Tennessee Demographic Data as of September 30, 2016[1]
UNAUDITED

Figure 4

Veteran Population by County



Source: Auditors created the map based on U.S. Department of Veterans Affairs data.

[1] This information represents the most current data available at the end of our fieldwork.

Figure 5

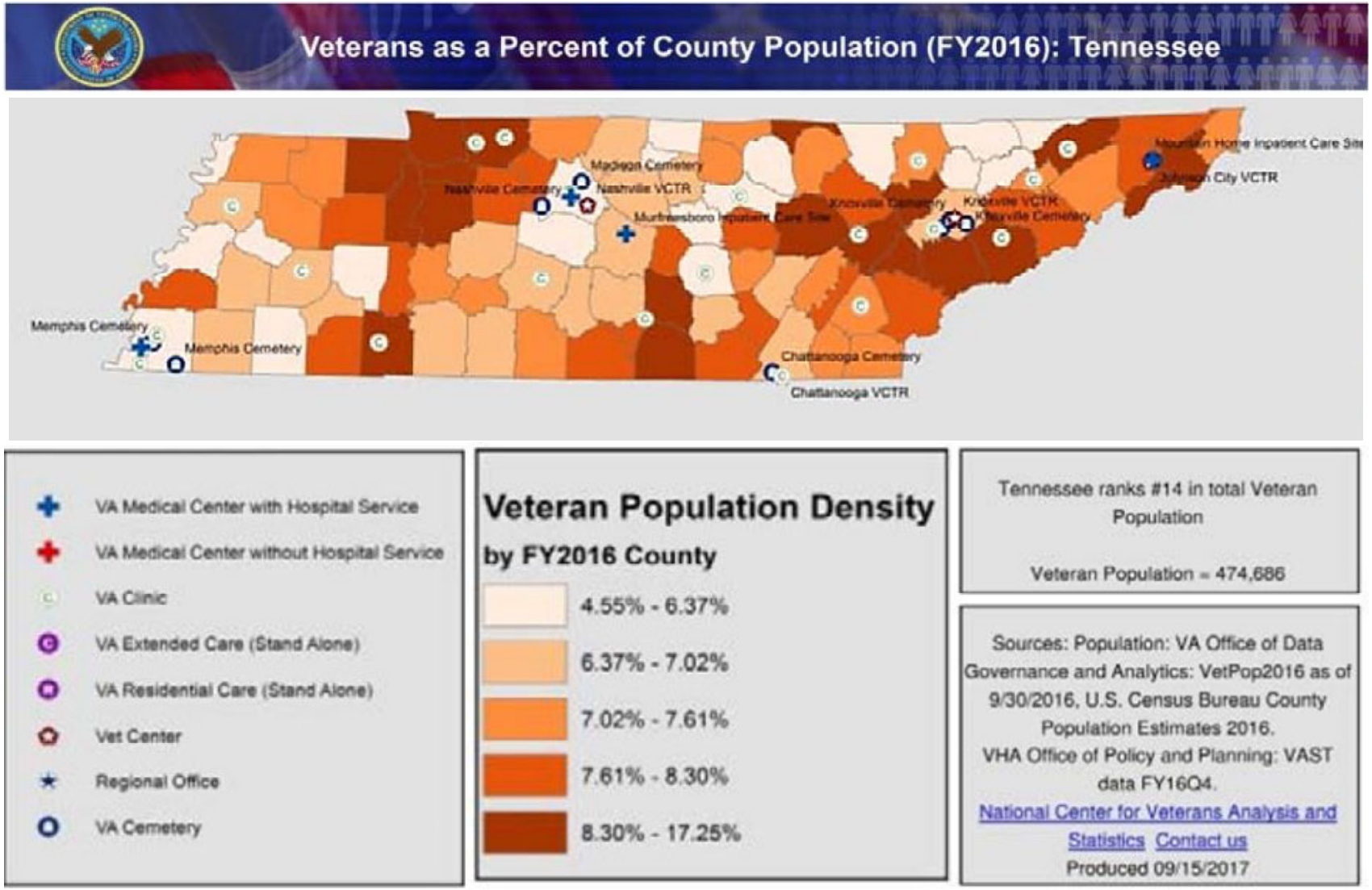

Veterans as a Percent of County Population (FY2016): Tennessee
Madison Cemetery
Nashville Cemetery
Nashville VCTR
Murfreesboro Inpatient Care Site
Knoxville Cemetery
Knoxville VCTR
Knoxville Cemetery
Mountain Home Inpatient Care Site
Johnson City VCTR
Memphis Cemetery
Memphis Cemetery
Chattanooga Cemetery
Chattanooga VCTR
VA Medical Center with Hospital Service
VA Medical Center without Hospital Service
VA Clinic
VA Extended Care (Stand Alone)
VA Residential Care (Stand Alone)
Vet Center
Regional Office
VA Cemetery
Veteran Population Density
by FY2016 County
4.55% - 6.37%
6.37% - 7.02%
7.02% - 7.61%
7.61% - 8.30%
8.30% - 17.25%
Tennessee ranks #14 in total Veteran Population
Veteran Population = 474,686
Sources: Population: VA Office of Data Governance and Analytics: VetPop2016 as of 9/30/2016, U.S. Census Bureau County Population Estimates 2016.
VHA Office of Policy and Planning: VAST data FY16Q4.
National Center for Veterans Analysis and Statistics Contact us
Produced 09/15/2017

Figure 6

Veteran Population (FY 2016)	Tennessee	National
Number of Veterans	474,686	20,392,192
Percent of Adult Population that are Veterans	9.27%	6.60%
Number of Women Veterans	43,550	1,860,516
Percent of Women Veterans	9.17%	9.12%
Number of Military Retirees	55,321	2,129,774
Percent of Veterans that are Military Retirees	11.65%	10.44%
Number of Veterans Age 65 and Over	212,587	9,560,748
Percent of Veterans Age 65 and Over	44.78%	46.88%

Figure 7

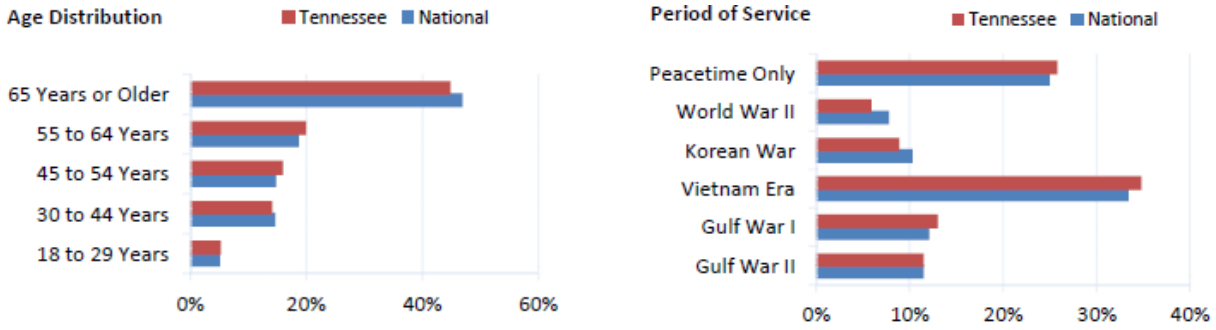


Figure 8

Population Change	Tennessee	National
Veteran Population FY 2015	479K	20.8M
Veteran Population FY 2045	319K	12M
Annual Percentage Change	-1.35%	-1.8%

Tennessee		9/30/2015	9/30/2020	9/30/2025	9/30/2030	9/30/2035	9/30/2040	9/30/2045
Age	Less than 40	67,192	67,129	61,921	55,725	53,675	53,739	53,879
	40-64	199,153	175,684	156,354	142,911	129,649	122,844	118,531
	65+	212,253	212,700	209,981	201,078	187,316	166,201	146,264

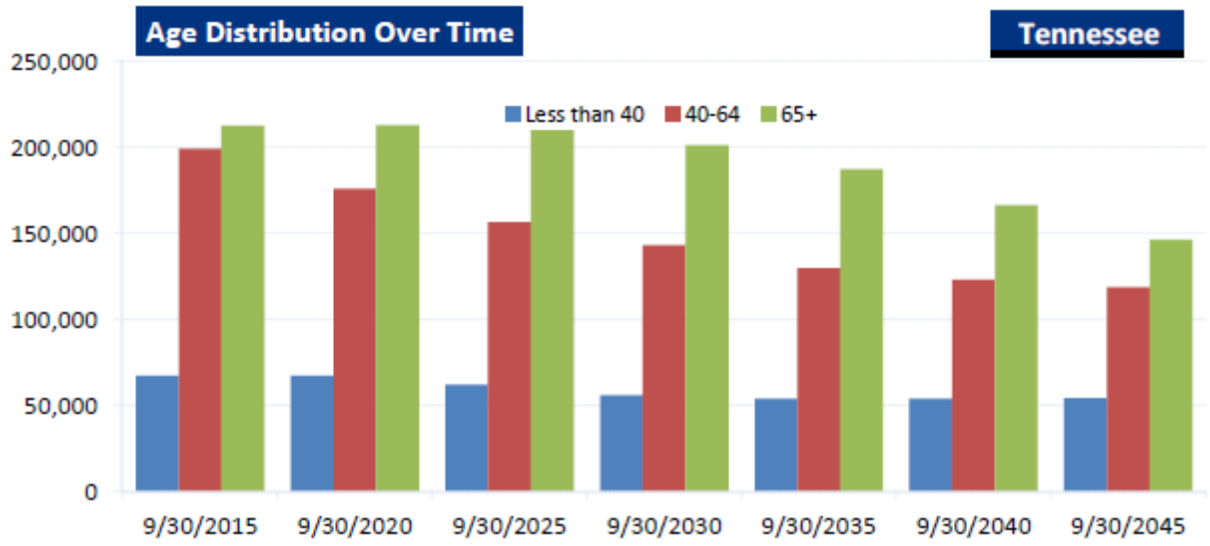
Tennessee		9/30/2015	9/30/2020	9/30/2025	9/30/2030	9/30/2035	9/30/2040	9/30/2045
Gender	Male	435,950	408,803	377,875	346,033	314,229	284,406	259,190
	Female	42,649	46,709	50,382	53,680	56,411	58,379	59,484

Tennessee		9/30/2015	9/30/2020	9/30/2025	9/30/2030	9/30/2035	9/30/2040	9/30/2045
Period of Service	WWII	15,847	5,328	1,139	151	11	0	0
	Korea	34,671	20,555	9,197	2,813	559	71	5
	Vietnam	168,926	151,896	128,671	99,572	67,165	37,309	16,023
	Gulf War	163,652	188,351	203,593	206,778	205,043	199,213	187,935

Tennessee		9/30/2015	9/30/2020	9/30/2025	9/30/2030	9/30/2035	9/30/2040	9/30/2045
Race	White, Not Hispanic	393,347	366,351	335,249	302,236	268,262	235,219	205,713
	Minority	85,252	89,161	93,008	97,477	102,378	107,565	112,962

Note: Minorities are all races/ethnicities except non-Hispanic White Veterans

Figure 9



AUDIT SCOPE

We have audited the Tennessee State Veterans' Homes Board for the period January 1, 2015, through June 30, 2018. Our audit scope included a review of internal controls and compliance with laws, regulations, policies, procedures, and provisions of contracts or grant agreements in the following areas:

- Resident Care
- Quality Control
- Human Resources
- Resident Admissions
- General Administration
- Board of Directors

The Tennessee State Veterans' Homes Board management is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, policies, procedures, and provisions of contracts and grant agreements.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

PRIOR AUDIT FINDINGS AND OBSERVATIONS

REPORT OF ACTIONS TAKEN ON PRIOR AUDIT FINDINGS AND OBSERVATIONS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. In response to the September 2012 sunset performance audit that contained three findings, the Tennessee State Veterans' Homes Board filed its report with the Comptroller of the Treasury on March 25, 2013. We issued a follow-up audit in November 2014, concluding that none of the prior findings had been fully addressed. As part of the current audit, we again conducted a follow-up of the three prior audit findings.

In addition to the findings, the September 2012 performance report included four observations. We followed up on select observations during our current audit. The observation concerning notice of public meetings and violations of the Open Meetings Act regarding the Executive Director's annual review has not been resolved and is repeated in the applicable section of this report.

RESOLVED AUDIT FINDING

The current audit disclosed that the Tennessee State Veterans' Homes Board has corrected the previous audit finding that recommended the homes' human resource directors be more involved in monitoring and reporting staff turnover and that management use a more professionally accepted formula when calculating staff turnover.

PARTIALLY RESOLVED AUDIT FINDINGS

The current audit disclosed that while the homes did not completely correct the previous emergency preparedness finding, they have achieved federal compliance due to the generalization of regulations. We have updated the status of this issue in an observation. The current audit also disclosed that the previous audit finding concerning monitoring contractors for compliance with Title VI of the Civil Rights Act of 1964 is partially resolved. The Tennessee State Veterans' Homes Board has corrected the portion of the finding recommending the board's involvement in the creation and implementation of a mechanism to monitor for Title VI compliance all contractors that provide service to residents. The portion of the finding recommending that board staff ensure that all contractors complete and return the Title VI self-survey by the annual deadline has not been resolved and is repeated in the applicable section of this report.

AUDIT CONCLUSIONS

ACHIEVEMENTS

Since January 1, 2015, the Tennessee State Veterans' Homes Board has celebrated multiple achievements.[2]

Clarksville Home Opened

Serious discussions to build a veterans' home in Clarksville began in the early to mid-2000s, with construction starting in May 2013. In December 2015, the 108-bed Brigadier General Wendell H. Gilbert Tennessee State Veterans' Home admitted its first residents. Governor Bill Haslam and other key stakeholders dedicated the new facility on January 11, 2016.

Figure 10
Clarksville Home Dedication

Source: Department of Veterans Services' annual report for fiscal year 2015-2016.

Occupancy Rates

All four veterans' homes enjoy occupancy rates well above the state average. See **Figure 11**.

[2] We developed the achievements listing in consultation and coordination with Tennessee State Veterans' Homes Board management.

Figure 11
Occupancy Rates as of March 2018

Home	Beds Occupied*	Home Rate**	State Average***
Murfreesboro (140 beds)	130	93%	74.7%
Humboldt (140 beds)	134	96%	74.7%
Knoxville (140 beds)	134	96%	74.7%
Clarksville (108 beds)	108	100%	74.7%
*	Source: Auditor calculation.		
**	Source: Board minutes.		
***	Source: Associated Press.		

Awards Received

The homes received the following awards during our audit period:

1. In 2015, *U.S. News & World Report* named the homes in Murfreesboro, Humboldt, and Knoxville among the best in the country. *U.S. News & World Report* used data from CMS to rate more than 16,000 nursing homes on safety, health inspections, and staffing.

2. On November 1, 2016, the Employer Support of the Guard and Reserve presented the homes with the Seven Seals Award for meritorious leadership and initiative in support of the men and women who serve the U.S. in the National Guard and Army Reserve.

3. All four state veterans' homes received the 2018 Customer Experience Award from Pinnacle Quality Insight. A total of seven Tennessee facilities received this Pinnacle award for overall satisfaction in post-acute care.

Other Recognition

In March 2015, the homes' Executive Director disclosed in a board meeting that the following states had contacted him for guidance: Texas, California, Michigan, Wyoming, and Arkansas. The Executive Director also participated in California's Little Hoover Commission hearing on March 3, 2016. The committee was particularly interested in the governance structure and funding model of the Tennessee State Veterans' Homes system.

RESIDENT CARE

Quality of Life

Management states on the Tennessee State Veterans' Homes website that the purpose of the homes is to

- Provide quality of care and quality of life for our veterans.
- Rehabilitate residents to the maximum attainable level of independent functioning by utilizing all necessary governmental and community services and therapies, and to provide a comfortable, safe, sanitary environment conducive to personal happiness.
- Make available to residents, social and cultural activities of personal interest designed to foster feelings of dignity and self-respect.
- Meet the individual needs of each resident to the greatest extent possible.

The homes offer a full range of services for residents, including long-term care and short-term rehabilitation. The homes provide residents with restaurant-style dining and a wide variety of entertaining activities. Management and staff are expected to give resident veterans all the necessary care and services to attain or maintain the highest physical, mental, and psychosocial well-being. Each home should care for residents in a manner that promotes improvement or at least maintenance of each resident's quality of life and dignity. This process involves assisting residents with their activities of daily life, including but not limited to bathing, dressing, grooming, eating, communicating, and ambulating.

Audit Results

Audit Objective: Did management establish and communicate to staff and other interested parties clear Quality of Life Standards for residents?

Conclusion: Based on audit work performed, management incorporated Quality of Life Standards established in federal guidance into the homes' internal policies (see Observation 1). However, we discovered that three of the four homes fell below average in federal Quality of Resident Care ratings during our audit period (see **Finding 1**).

Observation 1 – The veterans' homes communicate federal quality of life and quality of care standards through internal policies

Title 38, *Code of Federal Regulations* (CFR), Part 51, establishes standards to ensure that state homes provide veterans with the necessary care and services to develop or maintain the highest possible physical, mental, and emotional well-being. In order to convey these standards to staff responsible for

veterans' direct care, Tennessee State Veterans' Homes management, with the approval of the governing board, enacted the series of internal policies described in **Appendix 2**.

Finding 1– While overall federal ratings remained high during our audit period, three of the four veterans' homes received below-average scores in Quality of Resident Care

Based on the federal Nursing Home Reform Act of 1987 and more recent quality improvement campaigns such as Advancing Excellence in America's Nursing Homes, the Centers for Medicare and Medicaid Services (CMS) created the Five-Star Quality Rating System to help consumers, as well as their families and caregivers, compare nursing homes more easily.

CMS assigns each nursing home a rating between one and five stars. Nursing homes with five stars are considered to have "much above average" quality, while homes with three stars have "average" quality and those with one star have quality "much below average." CMS derives the nursing home ratings from three sources of data:

Figure 12
CMS Rating Components

The Quality Measures component encompasses Quality of Resident Care, which focuses on how well the nursing homes are caring for their residents' physical and clinical needs.

Within our audit period, each home scored high overall ratings; however, three of the four homes struggled in Quality of Resident Care.

Ratings Calculations

CMS uses multiple databases for its rating calculations (see **Figure 13**).

Figure 13
CMS Rating Calculation

1. **CMS's health inspection database** - Includes the nursing home characteristics and health deficiencies issued during the 3 most recent state inspections and recent complaint investigations. Data about penalties made against nursing homes also come from this database. Additional inspection data may be added to the database at any time because of complaint or facility reported incident investigations, outcomes of revisits, Informal Dispute Resolutions (IDR), or Independent Informal Dispute Resolutions (IIDR). These data may not be added in the same cycle as the standard inspection data. The following measures on Nursing Home Compare come from this data source:
    a. **Health inspections data**
    b. **Penalties**
2. **Payroll-Based Journal (PBJ) system** - The PBJ system allows nursing homes to electronically submit the number of hours facility staff are paid to work each day. The information is submitted quarterly, and is auditable to ensure accuracy. Staffing data are collected on the director of nursing, registered nurses with administrative duties, registered nurses, licensed practical nurses with administrative duties, licensed practical nurses, certified nurse aides, medication aides, and nurse aides in training. More information on this program is available here. The following measures on Nursing Home Compare come from this data source:
    a. **Total staffing**
    b. **RN staffing**
3. **The Minimum Data Set (MDS) national database** - Data for quality of resident care measures come from the MDS database. The MDS is an assessment done by the nursing home at regular intervals on every resident in a Medicare- or Medicaid-certified nursing home. Information is collected about the resident's health, physical functioning, mental status, and general well-being. These data are used by the nursing home to assess each resident's needs and develop a plan of care. The following measures on Nursing Home Compare come from this data source:
    a. **Quality of resident care**
    b. **Staffing (resident characteristics used to estimate the amount of staffing needed)**
    c. **Resident census (used in calculating staffing hours per resident day)**
4. **Medicare claims data** - CMS uses bills that nursing homes and hospitals submit to Medicare for payment purposes to identify when hospitalizations and nursing home admissions take place. These are used to calculate hospital readmission rates, emergency room visits, and discharges. The following measures on Nursing Home Compare come from this data source:
    a. **Quality of resident care**

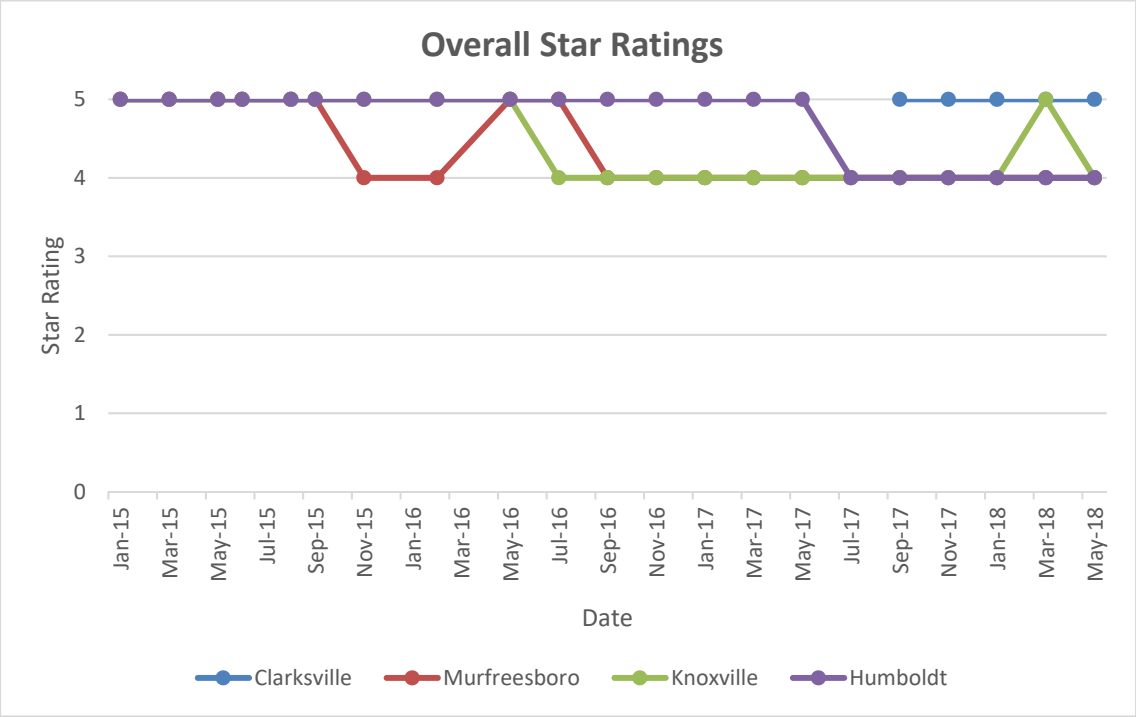
This information changes often, as residents are discharged and admitted, or residents' conditions change. The data on Nursing Home Compare should be used along with information from the Long-Term Care Ombudsman's office, the State Survey Agency, or other sources. Please see the Nursing Home Compare Technical Users' Guide for more information on where the data comes from.

Source: https://www.medicare.gov/NursingHomeCompare/Data/About.html.

Overall Quality Ratings

In 2014, CMS awarded five stars overall to the Murfreesboro, Humboldt, and Knoxville veterans' homes, which management considers an achievement. Through May 2018, these three homes—as well as Clarksville—have continuously earned ratings of either four or five stars (see **Figure 14**).

Figure 14*

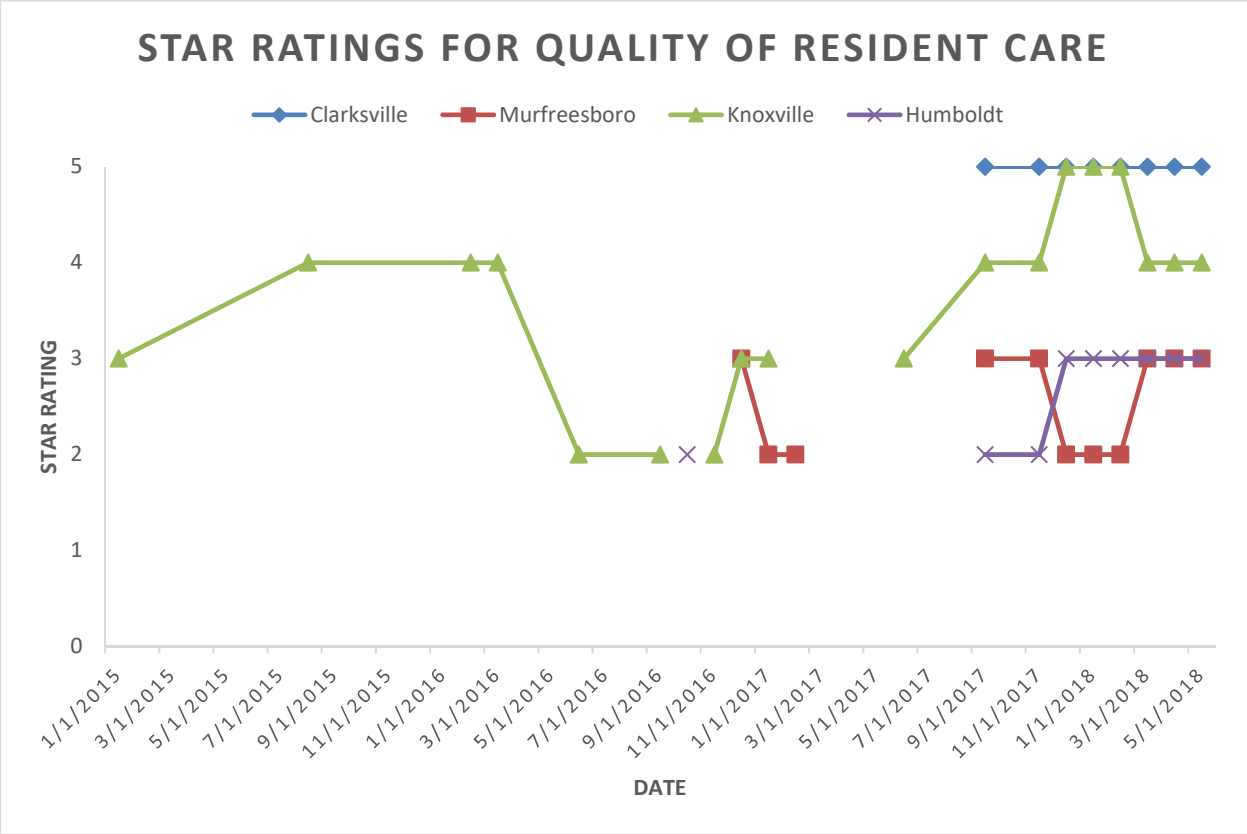


Source: Overall CMS star ratings obtained from board minutes.
*Based on discussion with management, the Clarksville home received its first CMS rating in September 2017, following its opening in December 2015.

Quality of Resident Care Ratings

Despite the superior overall ratings, the homes' Quality of Resident Care ratings have varied significantly. Murfreesboro, Humboldt, and Knoxville in particular have received two-star ratings, which CMS classifies as below average, at differing points during our audit period (see **Figure 15**).

Figure 15*



Source: CMS Quality of Resident Care star rating data obtained from management.
*The gaps in the chart are intentional. Our discussions with management revealed that while they actively maintained a history of the homes' overall CMS ratings, they do not do the same for the individual rating components. Consequently, they could not provide us with all monthly Quality of Resident Care ratings. Neither we nor management could pull past ratings from the CMS website. Management added that as far as they were aware, they did not have a CMS contact who could generate all ratings for the duration of our audit period. Maintaining the rating history could improve management's ability to gauge the homes' progress.

In **Appendix 3**, we present the full CMS Quality of Resident Care reports for each home as of May 2018, as well as the data collection periods used.

Lower Ratings for Murfreesboro and Humboldt

Based on our analysis of available data, the Murfreesboro and Humboldt homes consistently scored lower in Quality of Resident Care than the Knoxville and Clarksville homes. Management explained that these differences arose as a result of patient mix. Specifically, both Knoxville and Clarksville typically have had a higher number of residents that are short-term rehabilitation with a probable discharge to their personal home as opposed to long-term residents who will remain at the state veterans' homes indefinitely. The short-term residents tend to be younger and stronger than the long-term residents. Because the short-term residents have temporarily reduced strength and

Examples of Activities of Daily Living

- bathing or showering;
- dressing;
- getting in and out of a bed or chair;
- walking;
- using the toilet; and
- eating.

ability due to surgical or other health-compromising events and the veterans' homes staff are able to help return them to their former norm regarding activities of daily living (ADL), the homes tend to earn higher quality measure scores for those residents.

According to management, Murfreesboro and Humboldt have a much larger long-term care population, which in turn increases the negative triggering of the quality measures, especially those involving decline in ADL and locomotion. Management attributes these declines to the normal aging process.

We further observed that Murfreesboro had a two-star rating as recently as February 2018. When we asked members of management about the steps implemented to subsequently raise the rating to three stars, they pointed to updated staff training, resident turnover, a more relaxed CMS process to account for urinary tract infections (UTIs), and improvement in resident care planning. Murfreesboro had particularly made progress in the following quality measures: lower percentages of residents who reported moderate to severe pain, received antipsychotic medication, had a UTI, had a catheter inserted and left in their bladder, needed increased help with ADL decline, experienced worsened independent movement, and lost too much weight.

Quality of Resident Care Improvement Plans

Regarding plans for improving quality of resident care, management noted that the homes' ongoing Quality Assurance process functions in this role and that care quality issues are usually addressed during individual care plan development, as well as daily and monthly meetings. We, however, drafted findings on both the homes' assessments used to develop care plans and the homes' Quality Assurance Committees and subcommittees. Management stated that since May 2018, they have initiated organization-wide Executive Performance Improvement Projects involving staff retention and recruitment, preventing resident falls, and antipsychotic drug use.

Additional Resident Care Findings

See **Finding 2** for further details on the homes' assessment process and **Finding 5** for more information on the homes' Quality Assurance Committees and subcommittees.

Management commented, and we verified through monthly reports for each home, that they monitor the Quality of Resident Care measures that CMS uses.

Effects of Low Ratings

According to the homes' fiscal year 2017 annual report, "The central purpose and role of the Tennessee State Veterans' Homes Board is to: . . . Provide quality of care and quality of life for our veterans." The Quality of Resident Care ratings directly reflect the veterans' quality of care and quality of life; therefore, lower ratings indicate that improvements are needed in those areas.

Recommendation

Going forward, management should

- continue to maintain the homes' high overall CMS ratings;
- take the necessary steps to ensure that none of the homes falls below average in Quality of Resident Care—or any of the other individual rating components—for any length of time; and
- maintain the complete history of the individual CMS rating components since that practice will help keep the homes' purpose and goals in the forefront.

Management's Comment

We concur. Tennessee State Veterans' Homes Executive Management will continue to strive to maintain the highest overall CMS ratings for all homes. Management will ensure all the historical individual CMS rating components are maintained by the Director of Clinical Reimbursement. Management will continue to develop the Executive Performance Improvement Projects that were implemented in May 2018 with focus on CMS quality measures.

Assessments

In order to individualize care plans to ensure each resident receives the most appropriate care and enjoys the best possible quality of life, the homes utilize assessments. The objectives of these assessments include establishing the resident's current condition, identifying risk factors for the resident (such as determining if the resident has a high risk of falling), and helping staff determine appropriate therapies and interventions (such as bed rails or feeding assistance). Some examples of resident assessments are

- pre-admission evaluations and assessments;
- Long-Term Care Minimum Data Set (MDS);
- admissions assessments;
- cognitive assessments;
- quarterly and annual assessments; and
- significant change assessments.

Some assessments are federally required, such as the MDS, which is a standardized assessment that all homes certified to participate in Medicare or Medicaid are required to use, and the U.S. Department of Veterans Affairs' (VA) State Home Program Application for Veteran Care Medical Certification (VA Form 10-10SH). Other assessments are state-required, such as the Pre-Admission Evaluation Application used in applying for TennCare services. In addition to these externally required assessments, management established internal policies mandating specific assessments upon a resident's admission/readmission, at quarterly and annual intervals, and with any significant changes to a resident's health. We focused our audit scope on the assessments

required by the homes' "Admissions Assessment" policy and the "Quarterly/Annual/Significant Change Assessment" policy.

Admissions Assessments

Admissions to one of the homes start with a referral, which the homes usually receive from a hospital or another nursing facility. During the admission process, the on-duty nurse in the home will complete clinical admission assessments on the day of admission. The "Admissions Assessment" policy, which was approved on January 7, 2013, stipulates that licensed nursing staff in the home must complete admissions assessments within specified timeframes. See **Table 2** for details. By completing these assessments, the facility helps to ensure the residents' level of care.

Table 2
Admissions Assessments

Assessment Type	Deadline	Purpose
Skin Assessment	Within 2 hours of admission	To determine if a resident has any skin sores or wounds and the resident's risk for developing such sores or wounds.
Hydration Status	Within 2 hours of admission	To determine a resident's preliminary hydration status upon admission
Initial Verbal Pain Interview	Within 1 hour of admission	To determine a resident's preliminary pain level upon admission
Heart, Lung and Bowel Assessment	Within 1 hour of admission	To listen to a resident's heart, lung, and bowel sounds and establish the time of the last bowel movement
Fall Assessment	Within 8 hours of admission	To assess a resident's risk for falls and determine appropriate interventions to prevent falls
Dehydration Assessment	Within 8 hours of admission	To assess a resident's risk for dehydration and determine appropriate treatment to treat or prevent dehydration
Pain Assessment	Within 8 hours of admission	To comprehensively assess a resident's pain level to establish appropriate pain management
Bowel and Bladder Assessment	Within 8 hours of admission	To determine a resident's continence level and establish an appropriate toileting program
Nursing Assessment	Within 24 hours of admission	To complete assessments of the resident's other vital signs as determined necessary

Quarterly, Annual, and Significant Change Assessments

As time passes, residents age, their health status alters, and their individualized needs change. One way the homes' staff ensure they keep their residents' care plans up-to-date is to conduct assessments quarterly, annually,[3] and when the resident experiences a significant change in health. The "Quarterly/Annual/Significant Change Assessment" policy, which was approved on January 7, 2013, requires that licensed nursing staff in the home complete the assessments described in **Table 3**.

Table 3
Quarterly/Annual/Significant Change Assessments

Assessment Type	Assessment Purpose
Fall Assessment	To assess a resident's risk for falls and determine appropriate interventions to prevent falls
Braden Scale	To assess a resident's risk of developing pressure sores
Pain Assessment	To assess a resident's pain levels to ensure pain is managed appropriately
Hydration Assessment	To assess a resident's risk for dehydration
Restraint Assessment[4] (for residents with restraints)	To assess the appropriateness of continued use of restraints for residents who need them.

Audit Results

Audit Objective: Did management ensure resident assessments were performed in accordance with the "Admission Assessments" policy and the "Quarterly/Annual/Significant Change Assessments" policy?

Conclusion: Based on audit work performed, management did not have adequate controls in place to ensure staff properly conducted assessments (see **Finding 2**).

[3] The annual assessment is the same as the assessment for the fourth quarter. It is documented in records as a quarterly assessment.

[4] Restraints include, but are not limited to, the use of devices to prevent residents from falling and injuring themselves such as (a) bedrails or (b) chemical restraints in cases where residents are at risk for harming themselves or others.

Direct Care Providers

The homes do not employ physicians or specialists on their staff. Instead, the homes contract with local direct care providers who offer physician services, serve as medical directors, and extend specialized services such as psychological care. The direct care providers come to the homes to visit, evaluate, and treat residents. According to the homes' "Physician Visits Policy,"

> Physicians at Tennessee State Veterans' Homes will review the resident's total program of care, including medications and treatments at each visit. Physicians will visit residents according to CMS guidelines and as needed. Physicians will write, sign and date progress notes at each visit and sign and date all orders. Total program of care includes all care the facility provides residents to maintain or improve their highest practicable mental and physical functional status as defined by the comprehensive assessment and plan of care.

For residents whose stay is funded by the VA, the direct care providers bill the homes for the residents' care. If the residents' care is funded by other sources such as Medicare, Medicaid, or private insurance, the direct care providers bill those agencies directly. When direct care providers bill the homes, a nurse compares the billing to resident notes to verify the direct care provider performed the service.

Audit Results

Audit Objective: Did management have controls in place to ensure direct care providers only billed for services rendered?

Conclusion: Management did not have adequate controls in place to ensure direct care providers only billed for services rendered (see **Finding 2**). In addition, our office is investigating some of the direct care providers who provide care to residents in the homes. We will issue a separate report regarding the results of that investigation.

Finding 2 – The Tennessee State Veterans' Homes executive management did not have adequate internal controls in place over the resident assessment processes and monitoring of contracted direct care providers

Since assessments drive the development of a resident's care plan—including the medication, therapy, and other treatments prescribed—completing assessments late or not at all could result in an inadequate level of care provided to the resident. For example, if staff do not complete an assessment of a resident's fall risk, they can miss intervention opportunities, which might result in serious injury or worse to the resident. Our audit work revealed, however, that management did not have adequate controls in place to ensure that resident assessments were completed timely and in accordance with federal, state, and internal regulations.

Additionally, we found management lacked controls regarding monitoring the attendance and work of doctors contracted to perform services in the home. By not maintaining a strong system of internal controls regarding resident assessments of all types and direct care services performed by contractors, management increases the risk that the homes may not fulfill their central purpose to "[m]eet the individual needs of each resident to the greatest extent possible" and also increases opportunities for staff and contractors to commit fraud, waste, or abuse.

While the scope of our audit did not encompass all resident assessments conducted or the monitoring over all contracted direct care providers, the issues we identified were pervasive enough that we question the integrity of controls over the entire assessment process and the monitoring of contractors. We discuss below the details of the issues noted during our audit work.

Admissions Assessments

The homes' internal policy contains requirements for admissions assessments (see **Figure 16**).

Figure 16
Excerpt From the Homes' "Admission Assessments Policy"

Each Resident who is admitted and/or readmitted shall have an admission nursing assessment begun by the licensed nursing staff as soon as possible upon admission and completed within 24 hours. A Nursing assessment will include, but not necessarily limited to lung sounds, heart sounds, bowel sounds, last bowel movement and vital signs, including a current pain scale. Admission assessments may be completed by licensed nursing staff in accordance with state law and facility policy. This includes Licensed Practical nurses and Registered nurses. The assessment will be completed within 24 hours with the following exceptions.

A. Skin Assessment to be completed within 2 hours of admission

B. Assess and document current hydration status to be completed within 2 hours of admission

C. Initial verbal pain interview to be completed within 1 hour of admission

D. Heart, lung and bowel assessment will take place within 1 hour of admission

The following will be completed within 8 hours of admission:

A. Fall Assessment

B. Dehydration Assessment

C. Pain Assessment

D. Bowel and bladder

The remaining admission paperwork will be completed within the 24 hour period.

To determine whether the nurse on duty during the admission of new residents completed the resident admission assessments as required by the homes' "Admissions Assessments Policy," we selected a random, nonstatistical sample of 60 residents, 15 residents from each of the 4 homes, from a population of 1,693 total residents[5] that entered the homes during the period January 1, 2015, through March 29, 2018. Our testwork revealed that for 11 of 60 residents in our sample (18%), the nurse on duty did not complete 1 or more admission assessments in accordance with policy. Specifically, the on-duty nurse completed 20 admission assessments between 2 hours and 9 days late (see **Table 4**) and did not complete 13 additional admission assessments at all (see **Table 5**). We also noted that for 1 of 60 residents in our sample (2%), the on-duty nurse did not complete the new resident admission Basic Information/Medical History assessment paperwork.

Table 4 – Assessments Completed Late

	Clarksville	Murfreesboro	Knoxville	Humboldt	**Totals**
Number of Assessments Tested	15	15	15	15	**60**
Fall Assessment (Within 8 hours)					
# Late	3	1	-	2	**6**
Hours/Range of Hours Late	11-20	2	-	2-3.5	**2-20**
Average Hours Late	14	2	-	2.75	**8**
Dehydration Assessment (Within 8 hours)					
# Late	2	1	-	2	**5**
Hours/Range of Hours Late	11-20	2	-	2-11	**2-20**
Average Hours Late	15.5	2	-	6.5	**8**
Pain Assessment (Within 8 hours)					
# Late	2	1	-	1	**4**
Hours/Range of Hours Late	11-20	2	-	2	**2-20**
Average Hours Late	15.5	2	-	2	**8**
Bowel and Bladder Assessment (Within 8 hours)					
# Late	2	2	-	1	**5**
Hours/Range of Hours Late	11-20	2-216	-	2	**2-216**
Average Hours Late	15.5	109	-	2	**109**

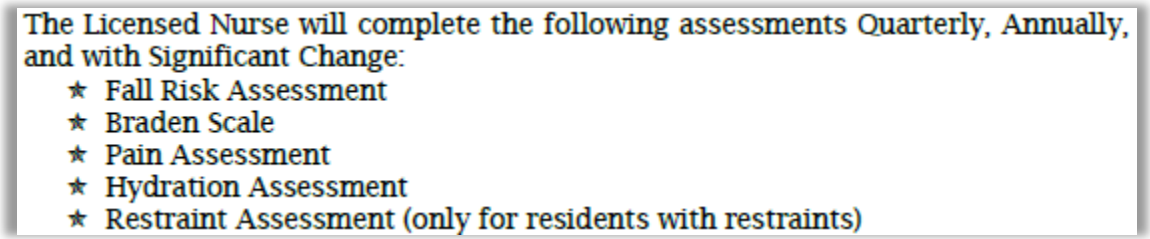
[5] The population breakdown of residents per home is as follows: Murfreesboro – 440; Humboldt – 491, Knoxville – 462, and Clarksville – 300.

Table 5 - Assessments Not Completed					
Assessment Type	Clarksville	Murfreesboro	Knoxville	Humboldt	**Totals**
	# Not Completed	# Not Completed	# Not Completed	# Not Completed	**# Not Completed**
Verbal Pain Interview (Within 1 hour)	1	-	-	-	**1**
Heart, Lung, and Bladder Assessment (Within 1 hour)	2	-	-	-	**2**
Skin Assessments (Within 2 hours)	1	-	-	-	**1**
Hydration Status (Within 2 hours)	2	-	-	-	**2**
Nursing Assessment (Within 24 hours)	1	-	-	-	**1**
Dehydration Assessment (Within 8 hours)	-	-	2	-	**2**
Pain Assessment (Within 8 hours)	-	-	2	-	**2**
Bowel and Bladder Assessment (Within 8 hours)	2	-	-	-	**2**

Quarterly/Annual/Significant Change Assessments

The homes additionally perform certain assessments quarterly, annually, and with significant changes (see **Figure 17**).

Figure 17
Excerpt From the Homes' "Quarterly/Annual/Significant Change Assessment" Policy


The Licensed Nurse will complete the following assessments Quarterly, Annually, and with Significant Change:
- ★ Fall Risk Assessment
- ★ Braden Scale
- ★ Pain Assessment
- ★ Hydration Assessment
- ★ Restraint Assessment (only for residents with restraints)

Management's policy did not specify a method for calculating the due dates for quarterly or annual assessments, but based on discussions with management, their practice was to consider assessments on time that were conducted within 15 days of the quarter end.

To determine whether the nurse on duty properly completed the quarterly, annual, or significant change assessments, we tested a random, nonstatistical sample of 35[6] residents from a population of 2,036 residents[7] who resided in the homes during the period January 1, 2015, through March 29, 2018. Our testwork revealed that for 23 of 35 residents (66%), the on-duty nurse did not complete 1 or more assessments as required by internal policy. Specifically, for these residents, we found that the nurse completed 27 quarterly assessments between 1 and 16 days late (see **Table 6**) and did not maintain records that staff completed 153 total quarterly, annual, and significant change assessments (see **Table 7**).

Table 6 - Late Assessments - Quarterly*

Assessment Type	Clarksville	Murfreesboro	Knoxville	Humboldt	Totals
Fall Risk Assessment					
# Late	1	2	-	1	**4**
Days/Range of Days Late	1	10-11	-	1	**1-11**
Average Days Late	1	10.5	-	1	**6**
Braden Scale					
# Late	2	3	1	1	**7**
Days/Range of Days Late	1	10-15	1	1	**1-15**
Average Days Late	1	12	1	1	**8**
Pain Assessment					
# Late	2	2	1	1	**6**
Days/Range of Days Late	1	10-11	1	1	**1-11**
Average Days Late	1	10.5	1	1	**6**
Hydration					
# Late	2	2	1	1	**6**
Days/Range of Days Late	1	10-11	2	2	**1-11**
Average Days Late	1	10.5	2	2	**6**

[6] We originally selected a sample of 60 residents, 15 from each of the 4 homes, from a population of 2,036 residents that resided in the homes during the period January 1, 2015, through March 29, 2018. We determined during our testwork that 25 of the 60 residents selected (42%) were not in the homes long enough to require quarterly assessments and that they did not experience any significant changes during their stay to warrant significant change assessments; when we excluded these residents from our sample, the resulting sample size was 35. Due to the overall error rate of our testwork, we determined selecting and testing additional items to reach a sample size of 60 would not change our conclusion that staff did not complete assessments as required by internal policy.

[7] The population breakdown for residents per home is as follows: Murfreesboro – 551, Humboldt – 596, Knoxville – 586, and Clarksville – 303. Since the residents were not always in the homes for the same length of time and since not every resident underwent significant changes that triggered a need for assessments, the number of assessments required for each resident varied.

Restraint						
	# Late	-	2	1	1	**4**
	Days/Range of Days Late	-	10-11	1	1	**1-11**
	Average Days Late	-	10.5	1	1	**6**
Grand Total of Late Assessments						**27**

*The days late listed refer to those in excess of management's 15-day allowance.

The Director of Clinical Services stated staff did not always complete these assessments timely or at all because the assessments are not required federally or by the state. While we understand these assessments were not required by an outside entity, management clearly considered these assessments important enough to include them in an internal policy, which states, "Nurses who fail to complete their assigned assessments timely will be reprimanded. Repeat offenders will be terminated for inadequate performance. These assessments are very important and will be treated as such." Furthermore, the Director of Clinical Services explained to us that the internal policy was developed as an additional mechanism to ensure residents' conditions were regularly assessed and that their care plans, including necessary interventions such as those used to prevent falls, were up-to-date.

Medical Certifications

Management at the homes reported to our office that staff at the Humboldt home created and submitted invalid medical certification forms for residents applying for benefits from the federal Veterans State Nursing Care Program and for residents applying for TennCare Medicaid services. The forms certify the accuracy of the information in the medical evaluation portions of the respective forms, which TennCare uses to determine a resident's eligibility for services and reimbursements. Management disclosed how they handled the situation with their staff and that they had reported the TennCare Medicaid issue to the State Attorney General's Office. Our office conducted the homes' financial statement audit for the fiscal year ended June 30, 2017, and this issue is discussed in our audit report. See http://www.comptroller.tn.gov/repository/SA/ag18050.pdf for the financial statement audit report.

The U.S. Department of Veterans Affairs (VA) requires the submission of a VA Form 10-10SH to the Veterans Affairs medical center of jurisdiction for each veteran within 10 calendar days of admission per Title 38, *Code of Federal Regulations*, Part 51, Section 43(a), which states,

> As a condition for receiving payment of per diem under this part, the State home must submit to the VA medical center of jurisdiction for each veteran a completed VA Form 10-10EZ, Application for Medical Benefits, and a completed VA Form 10-10SH, State Home Program Application for Care – Medical Certification. These VA Forms must be submitted at the time of admission, with any request for a change in the level of care, and any time the contact information has changed. If the facility is eligible to receive per diem payments for a veteran, VA will pay per diem under this part from the date of receipt of the completed forms required by this paragraph, except that VA will pay per diem from the day on which the veteran was admitted to the facility if the completed forms are received within 10 days after admission.

TennCare similarly mandates the submission of Pre-Admission Evaluation forms (PAEs). Section 9.2 – MD [Medical Doctor] Certification for NF [Nursing Facility] Requests of the 2014 *TennCare Long Term Services and Supports: A Guide to Pre Admission Evaluation Applications* establishes

> An original physician's signature is required when submitting a PAE and any revisions or recertifications. PAEs will not be approved for NF LOC [Level of Care] unless the certification form is filled out in its entirety and the physician (or PA [Physician Assistant], NP [Nurse Practitioner] as applicable) has signed the statement on the PAE Certification page certifying the applicant requires the level of care provided in a nursing facility and that the requested long term care services are medically necessary for the applicant...Anytime, it appears that a Certification Signature is duplicated or not an original signature, a referral to TennCare's Program Integrity Unit must be made.

TennCare Rule 1200-13-01-.02(21) requires certification, which it defines as

> A process by which a Physician who is licensed as a doctor of medicine or doctor of osteopathy signs and dates a PAE signifying the following: 1. The person requires the requested level of institutional care or reimbursement . . . and 2. The requested LTSS [Long-Term Services and Supports] are medically necessary for the individual.

Direct Care Providers

During the audit, employees in the home alleged that multiple direct providers documented progress notes for times they were not present in the home. Management confirmed they banned one direct care provider from practicing in the homes due to fraud concerns. Based on our testwork, contracted direct care providers—such as attending physicians, mental health professionals, and other specialists—were not required to sign in or out of the homes, and management did not have other compensating controls in place to account for when direct care providers went to the homes to provide care services to residents.

Ongoing Investigation

The homes' lack of controls created an opportunity for direct care providers to falsify resident case notes and bill for resident services they did not necessarily provide. While we completed our audit work at the homes related to this issue, our office is conducting an investigation into some of the providers contracted to provide direct care to residents in the homes; we will issue a separate report regarding the results of the investigation.

Other Assessment Control Issues

Management reported to us that they identified an incident where a social worker in the Murfreesboro home fabricated a cognitive assessment for one of the residents. While we believe management appropriately responded to the incident by terminating the social worker's employment, the incident illuminated an absence of controls to ensure staff truly conducted assessments. Without appropriate controls in place to ensure staff conducted resident

assessments and reported truthful results, management created an opportunity for doubt as to the validity of assessments performed by staff and the appropriateness of services residents received because of assessments conducted.

Recommendation

The Executive Director and nursing management should

- ensure management and staff understand and emphasize the importance of conducting and complying with guidance regarding all resident assessments, whether they are required by an outside entity or by internal policy;
- consider amending internal policy to establish clear deadlines and allowances for exceeding those deadlines (such as the 15-day rule discussed above) for quarterly, annual, and significant change assessments;
- ensure staff in each of the homes conduct admissions, quarterly, annual, and significant change assessments as described in internal policy;
- develop and implement internal controls to ensure assessments conducted are accurate and truthful, such as having the resident sign off or a second nurse sign off in cases where residents are unable to affirm the service was completed; and
- ensure that staff who do not complete assessments appropriately are reeducated or reprimanded, based on management's discretion.

The Executive Director should also consider implementing controls to ensure the homes retain records demonstrating when direct care providers are on site to provide care to residents, as these records create an additional level of verification to ensure payments made to contracted direct care providers are accurate and only encompass services provided to residents.

Management's Comment

We concur in part. The TSVH concurs that there were some TSVH internal admission assessments that according to policy were out of the timeframe; however, quality of care was not compromised. The Nurse generally performs the assessment and then documents the assessment into the Electronic Health Record. The TSVH does not have computers at the bedside for the assessment(s) to be documented in real time; therefore, even though the assessment(s) may have been completed in a timely fashion, the computer program date and time stamps the moment that the assessment is entered into the program. Going forward, the Clinical assessment policy will be updated and education provided by November 15, 2018.

The TSVH does not concur that the Quarterly, Annual, or Significant Change assessments were late. The policy does not state a timeframe for these assessments to be completed. The assessments in question are not required by the federal or state regulations. The policy will be updated and education provided by November 15, 2018.

TSVHB does not concur with the finding as written that the W.D. 'Bill' Manning facility "created and submitted invalid pre-admission evaluation applications (PAEs) for residents applying for TennCare Medicaid services."

TSVHB does concur with the finding that the Facility Administrator did identify that a single member of the Facility staff obtained and submitted physician certification forms (which are a portion of the PAE application) that contained non-original signatures of the certifying physician. TSVHB further agrees that PAEs were submitted for residents applying for TennCare nursing facility services which included physician certifications containing non-original signatures of the certifying physician.

At the recommendation of counsel and at this stage of its investigation, TSVHB cannot comment, and cannot concur with any finding related to the scope of the submission of PAEs containing non-original signatures of the certifying physician. Further, TSVHB cannot comment or concur with any determination regarding either (a) the existence of any overpayment relating to claims paid for residents, or (b) if any such overpayment exists, the amount of such overpayment and how it is determined.

At the recommendation of counsel and at this stage of its investigation, TSVHB does not concur with the finding that the Facility submitted "invalid pre-admission evaluation applications." No allegations or facts exist that information related to the individual's condition submitted with the PAE forms in question was inaccurate, or that the resident did not require the level of care or it was not medically necessary. It disagrees with the finding that any PAEs submitted should be characterized as "invalid."

TSVHB concurs with the recommendation that Management should ensure adherence to applicable regulations required by state and federal agencies that apply to resident certifications and the admissions process.

Because the Facility is conducting an ongoing investigation into this matter with the assistance of counsel, nothing within this management's response should be construed to be an admission of any regulatory violation, or any legal liability, on the part of the TSVHB. Additionally, because TSVHB is assisted by counsel in this investigation, the responses provided do not waive attorney client or any other privilege that may be asserted by TSVHB.

TSVHB does not concur with the finding as written that the W.D. 'Bill' Manning facility "created and submitted invalid medical certification forms for residents applying for benefits from the federal Veterans State Nursing Care Program." VHA Handbook 1601SH.01 (Transmittal Sheet August 25, 2011) states, "The medical need for the level of care applied for must be verified in writing on the VA Form 10-10SH by the signature of a VA physician or a qualified licensed physician assistant or nurse practitioner currently employed in a VA long-term care setting. If the forms lack sufficient information to make a level of care determination, VA asks the SVH to provide additional information (for example, a recent discharge summary or a history and physical narrative)." The 10-10SH form requires multiple signatures from different disciplines. The signature of primary physician assigned line (line 44) is not a certification made by the physician. Per the VA, anyone can complete part-II of the 10-10SH form.

TSVHB does concur with the finding that the Facility medical director pre-signed blank 10-10SH forms indicating he was the primary assigned physician. TSVHB agrees this is not good business practice and terminated the process immediately once it was identified.

TSVHB will implement a process documenting when direct care providers are onsite by December 31, 2018.

Medicine Distribution and Controls

One critical part of care plan administration involves ensuring residents receive the correct medications as prescribed by their physicians. In order to accomplish this task, management must have appropriate controls in place for medication receipt, storage, distribution, and disposal. The homes contract with a third-party pharmacy, which fills prescription orders (including for controlled substances such as Oxycodone, Morphine, and Lyrica) and delivers them to the homes. Upon delivery, the pharmacy provides a form detailing the date, medication, and prescription number. The Pharmacy Nurse verifies the forms' accuracy, signs off to confirm receipt of the stated medication, and saves the forms by resident name.

Management's expectations are that medicine distribution should not interrupt residents' activities of daily living and that nurses should not distribute medicine in room order to prevent creating an institutionalized atmosphere. To distribute medicine to a resident, the nurse

1. checks his or her file to determine the medicines needed at that time;
2. prepares the medicines;
3. gives the medicines to the resident;
4. makes sure the resident takes each medication; and
5. signs off that they distributed the medicine to the resident.

The homes tracked medicine distribution on paper until February 28, 2018, at which time the homes switched to computerized records. When the homes used paper records, the records would show a list of the resident's medicines plus the times the medicine needed to be distributed. Small boxes would represent each dose; to sign off that the medicine was distributed, the nurse would initial in the box representing that dose. The computerized system will show the nurse which medicines are due for distribution at a certain time; instead of signing off on paper, the nurse clicks a button in the system to document distributing the medicine. The outgoing nurse and oncoming nurse perform a medicine count at each shift change.

In addition to the controls surrounding distribution of medicines, a licensed pharmacist reviews each resident's medicine regimen monthly to identify irregularities in the regimen and make recommendations to the resident's physician and the Director of Nursing. The homes also have special medicine storage and disposal procedures, as well as procedures to handle the remaining medicine when a resident passes away or is discharged.

1. **Audit Objective:** Did management ensure internal controls were in place to account for medications classified as controlled substances?

   Conclusion: Our testwork disclosed that management had appropriate internal controls in place to account for medications classified as controlled substances.

2. **Audit Objective:** Did internal controls operate effectively to ensure medicines were dispensed to residents as prescribed?

   Conclusion: According to testwork, staff did not adequately document that they distributed medicines to residents as prescribed (see **Finding 3**).

Finding 3 – Nurses did not document that they had distributed all doses of medicine to residents as prescribed

Title 42, *Code of Federal Regulations* (CFR), Part 483, Section 70, requires nursing facilities to use their resources to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." For many residents, including those at the Tennessee State Veterans' Homes, medication is a key part of well-being.

When we examined veterans' medical records, though, we determined that the nurses on duty did not always document that they distributed medications as prescribed.

Testwork Results

For 62 residents,[8] we haphazardly selected one week to determine whether staff adequately distributed prescribed medications. Our testwork revealed that

- for 3 residents (5%), the Director of Clinical Services was unable to provide medicine distribution records because the homes had lost some of their record storage location files due to past computer issues; and
- for 22 of the remaining 59 residents (37%), the on-duty nurses did not document that they had distributed all doses of medicine as prescribed for the week tested (see **Table 8** for details).

[8] We selected for testwork a random, nonstatistical sample of 60 residents, 15 from each of the 4 veterans' homes, from a population of 2,036 individuals who resided in the homes during the period January 1, 2015, through March 29, 2018. In addition, we judgmentally determined to add a resident to our testwork, bringing our total to 61 residents. We asked management to pull the medical records for three randomly selected extra residents in case we could not test one or more items in our initial sample. Based on our review, two residents we selected were discharged the day after their admission to the home, so their files did not contain sufficient medicine distribution records to test. Therefore, we ended up with 62 residents to test.

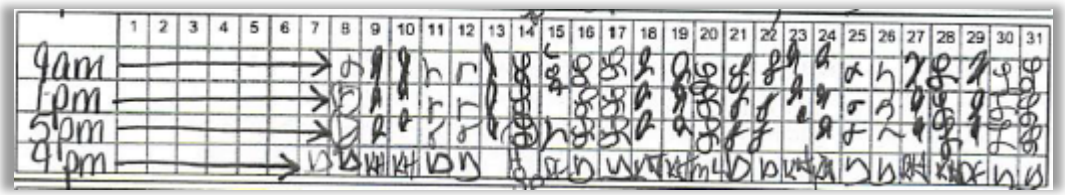
Table 8
Medicine Doses Not Documented as Distributed

	Location	Prescribed Medicine	Medical Information or Medicine Description	Doses Not Documented as Distributed
1	Murfreesboro	Mupirocin 2% ointment	Infection	10
2	Murfreesboro	Omeprazole 20mg tablet	Heartburn	1
3	Murfreesboro	Loratadine 10mg tablet	Allergy	1
4	Murfreesboro	Lasix 40mg tablet	Swelling lower extremities	14
5	Murfreesboro	1. Sertraline 100mg 2. Tamsulosin 0.4mg 3. Sitagliptin 100mg	1. Depression 2. Benign Prostatic Hyperplasia (BPH) 3. Diabetes	3 total
6	Clarksville	Artificial Tears Sterile 1.4%	Dry eyes	2
7	Clarksville	Multivit-Minerals tablet	Multivitamins	1
8	Knoxville	1. Clobetasol emollient 0.05% cream 2. Carbidopa-Levo 25mg/100 unit tablet	1. Unspecified skin condition 2. Parkinson's disease	4 total
9	Knoxville	1. Levothyroxine 125mg tablet 2. Omeprazole 40mg capsule 3. Finasteride F/C 5mg tablet 4. Tamsulosin HCL 0.4mg capsule	1. Hypothyroidism 2. Gastroesophageal reflux disease 3. BPH 4. BPH	4 total
10	Knoxville	Allopurinol 100mg tablet	Gout	1
11	Knoxville	Metoprolol Tartrate 50mg tablet	Hypothyroidism	1
12	Humboldt	Eliquis 5mg tablet	Anticoagulant	1
13	Humboldt	1. Pro-Stat 30ml 2. Midodrine 10mg tablet 3. Furosemide 20mg tablet 4. Spironolactone 25mg tablet	1. Nutritional supplement 2. Hypotension 3. Diuretic 4. Diuretic	6 total
14	Humboldt	Docusate Sodium 100mg softgel	Constipation	1
15	Humboldt	Sensipar 60mg tablet	Endocrine and metabolic agent	1
16	Murfreesboro	Carafate 1gm/10ml oral supplement	Ulcers	20
17	Murfreesboro	1. Ipratropium-Albuterol inhaler 2. Loratadine 10mg tablet 3. Venlafaxine HCL ER 225mg	1. Chronic obstructive pulmonary disease (COPD) 2. Allergies 3. Depression	9

		tablet 4. Ipratropium Bromide Nasal Solution 5. Lyrica 150mg tablet	4. Rhinitis 5. Pain	
18	Knoxville	Enoxaparin 40/0.4ml injection	Anticoagulant	1
19	Knoxville	1. Aspirin orange 81mg tablet 2. Bumetanide 1mg tablet 3. Metoprolol Tartrate 25mg tablet 4. Polyethylene Glycol 17gm/1 dose powder 5. Potassium Chl 20MEQ tablet 6. Flora Q	1. Miscellaneous 2. Edema 3. High blood pressure 4. Constipation 5. Diarrhea 6. Prevent or treat low potassium levels	6 total
20	Humboldt	1. DuoNeb 0.512.5 2. Neomycin 500 mg 1/1 tablet 3. Lactulose 20ml	1. COPD 2. Cirrhosis and high ammonia level 3. Cirrhosis and high ammonia level	4 total
21	Humboldt	Aquabase ointment	Dry skin	2
22	Humboldt	Anti-fungal cream	Treat fungus growth	2

Management explained that until February 28, 2018, the homes used a paper-based system to track medicine distribution. These papers sometimes extended to 20 or 30 pages with 4 or 5 different medicines per page and varying and/or multiple daily distribution times. Therefore, staff relied on a very intricate and labor-intensive process to both distribute each medication as prescribed and to document its distribution. This manual system was further limited by the fact that it could not automatically notify staff when the medicine needed to be dispensed, and staff were required to constantly review the paper records as a guide to medicine distribution per resident. We present an example of paper-based medicine distribution records in **Figure 18**.

Figure 18
Example of Paper-based Medicine Distribution Record



Management believes that by converting to an electronic-based recordkeeping system, the homes will remedy the medicine distribution issues. Based on our analysis of the paper-based system versus the month of electronic records included in our testwork, however, we did not note a significant improvement in error rates, as shown in **Table 9**.

Table 9
Paper Record Versus Electronic Record Error Rates

	Paper Records	Electronic Records	Total Records
Number Tested	48	11	59
Number of Residents With at Least One Dose Not Documented	18	4	22
Error Rate %	38%	36%	37%

Management acknowledged that converting to the new system involved a learning curve and would require staff training to ensure proper usage. Until management provides such training, we are unable to determine whether the electronic system will assist management in better documenting the distribution of medications.

Medical Record Regulation

According to 42 CFR 483.70(i), a nursing facility

must maintain medical records on each resident that are—

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized.

Consequences of Problems Detected

If nurses do not consistently document that they distributed prescribed medicines, other nurses, doctors, or reviewers cannot be certain whether residents received all necessary doses. On one hand, missing a dose could reduce the effectiveness of the medicine or even trigger an adverse health event. On the other hand, lacking documentation could lead a nurse to distribute a redundant dose, which could also trigger an adverse health event.

Recommendation

It is vital for residents' health that they receive the medicine prescribed by a doctor to ensure they receive optimum effects of the medicine. While management has already taken steps to simplify documentation by converting to an electronic process, management should ensure that internal controls over the electronic system mitigate risks of improperly medicating residents. Management should take immediate actions to revise or implement new controls as necessary to ensure nurses properly dispense and document that they distributed medicine to residents as prescribed.

Management's Comment

We concur in part. We concur that there is evidence that nurses failed to document they administered all medication. We do not concur that there is evidence nurses did not administer all medication. Moving forward, the Director of Nursing or designee will review the missed medication report daily (excluding non-worked days) and address any issues identified. The Director of Clinical Services or designee will review periodically for accuracy.

Death and Injuries

The population of residents within the homes is generally elderly and in compromised health. Therefore, the risk exists that over time residents will experience injuries and/or die of various causes. Death reporting requirements are found primarily in Chapter 1200-07-01.14(3), *Rules of the Tennessee Department of Health*, "Policy Planning and Assessment, Division of Vital Records," which states,

> All superintendents, managers, administrators or other persons in charge of hospitals, public or private nursing homes, or clinics, or other institutions, including penal institutions to which persons resort for treatment of disease, injury or childbirth or are committed by process of law shall report each birth, death, or fetal death occurring to the inmates of their institutions to the Local Registrar by the third day of the month after the event occurred. The report shall be made on a form furnished by the State Registrar and shall include all of the statistical information required by the State Registrar.

The rules do not include similar requirements for all injuries, and management does not have an established written policy for handling injuries that occur in the homes. Management does, however, have established practices for documenting and following up on such injuries. In PointClickCare, the information system used to store electronic resident records, injuries are divided into the following six categories:

- Fall with injury;
- Fall without injury;
- Low-bed to mat;[9]
- Skin tears;
- Bruise; and
- Miscellaneous.

Upon discovering a resident has fallen, the nurse will check the resident's vital signs and establish any necessary interventions to prevent another fall. According to management, residents should be asked immediately what happened because they will usually remember in the moment, but in 10 minutes they may not be able to even remember they fell. The nurse will talk to all witnesses, complete the incident report, and prepare an incident packet for later discussion.

[9] Some residents with risk of falling out of bed have a mat placed next to them while they sleep. If part of their body is off the bed and on the mat, this is considered a fall.

For other injuries, the nurse assesses the resident's condition to try to determine how the injury occurred. The nurse establishes interventions if needed to prevent another injury. The nurse completes the incident report and prepares an incident packet for later discussion.

The manager of each unit collects any incident packets prepared. During the morning meeting on the next business day, the doctors, nurses, and managers discuss the prior day's incidents and whether interventions put in place to prevent further incidents are appropriate. Additionally, the homes hold a second meeting weekly to specifically discuss resident falls.

Audit Results

1. **Audit Objective:** Did management analyze the causes of injuries to residents to identify trends and correct problems?

   Conclusion: Based on audit work performed, staff and management documented and reviewed all injuries that occurred in the homes to identify trends and prevent future problems.

2. **Audit Objective:** Did management report resident deaths accurately and timely as required?

   Conclusion: Management did not always report death dates accurately and did not always report them by the third day of the month, as required by the *Rules of the Department of Health* (see **Finding 4**).

Finding 4 – The homes' management did not ensure resident deaths were reported timely and accurately

When residents die at the veterans' homes, the homes' management must report these deaths in accordance with all applicable requirements. The requirements for reporting deaths are primarily in Chapter 1200-07-01.14(3), *Rules of the Tennessee Department of Health*, "Policy Planning and Assessment, Division of Vital Records" (see **Figure 19**).

Figure 19
Excerpt From Department of Health Rules

> All superintendents, managers, administrators or other persons in charge of hospitals, public or private nursing homes, or clinics, or other institutions, including penal institutions to which persons resort for treatment of disease, injury or childbirth or are committed by process of law shall report each birth, death, or fetal death occurring to the inmates of their institutions to the Local Registrar by the third day of the month after the event occurred. The report shall be made on a form furnished by the State Registrar and shall include all of the statistical information required by the State Registrar.

The veterans' homes specifically submit their monthly death reports to their respective county health departments.

Based on testwork performed,[10] we determined that the homes' staff did not accurately document or report 20 of 60 resident deaths (33%) as required. Our testwork revealed the following:

- For 10 of 60 resident deaths tested (17%), staff did not report the deaths to the local health departments by the third day of the following month. According to the Director of Clinical Services, the reporting problem for nine of the residents occurred because the homes misunderstood the deadline requirement. The staff in the homes believed the reporting deadline was the fifth of the month following the resident's death instead of the third. The reason for the late reporting of the remaining resident's death—Resident 3—is unknown (see **Table 10**).
- For 4 of 60 resident deaths tested (7%), while staff were able to demonstrate they had reported the deaths to the local health departments, they did not maintain documentation to prove that they submitted the reports within the required timeframe. Three of these errors occurred in Knoxville, and one occurred in Clarksville.
- For 2 of 60 resident deaths tested (3%), staff at the Humboldt home did not report any information to the local health departments. Management did not explain why the two Humboldt resident deaths were not reported.
- For 2 of 60 resident deaths tested (3%), staff at the Humboldt home reported resident death dates both inaccurately and untimely. According to the Director of Clinical Services, this was caused by human error and a misunderstanding of deadlines as noted above (see **Table 11**).
- For 1 of 60 resident deaths tested (2%), staff at the Humboldt home reported an inaccurate death date for a deceased resident to the local health department. According to the Director of Clinical Services, this was caused by human error (see **Table 12**).
- For 1 of 60 resident deaths tested (2%), staff at the Knoxville home incorrectly classified a resident as deceased in their records when in fact the resident was discharged from the home alive. According to the Director of Clinical Services, this was caused by human error and was limited to the resident's file; management did not inaccurately report to the local health department that the resident had died.

[10] To ensure the homes reported resident deaths as required, we obtained a complete listing of all 655 resident deaths which occurred within the four homes for the period January 1, 2015, through March 18, 2018. From this listing, we selected a nonstatistical random sample of 60 resident deaths, 15 from each of the 4 homes.

Table 10
Death Date Reported Late

Resident	Home	Actual Date of Death	Date Form Was Submitted	Number of Days Submitted Late
Resident 2	Murfreesboro	9-Apr-15	5-May-15	2
Resident 3	Murfreesboro	24-Oct-15	17-Nov-15	14
Resident 4	Murfreesboro	21-Sep-16	5-Oct-16	2
Resident 5	Clarksville	20-Dec-17	4-Jan-18	1
Resident 6	Clarksville	24-Jan-17	6-Feb-17	3
Resident 7	Knoxville	7-Jun-17	5-Jul-17	2
Resident 8	Humboldt	11-Mar-16	4-Apr-16	1
Resident 9	Humboldt	5-Mar-18	5-Apr-18	2
Resident 10	Clarksville	6-Dec-17	4-Jan-18	1
Resident 11	Humboldt	1-Dec-15	4-Jan-16	1

Table 11
Death Date Reported Both Inaccurately and Late

Resident	Home	Date of Death Reported to Vital Records	Actual Date of Death	Date Form was Submitted	Number of Days Submitted Late
Resident 12	Humboldt	26-Mar-16	23-Mar-16	4-Apr-16	1
Resident 13	Humboldt	15-Dec-15	22-Nov-15	4-Jan-16	32

Table 12
Incorrect Death Date Reported

Resident	Home	Actual Date of Death	Date of Death Reported to Vital Records
Resident 1	Humboldt	10-Nov-15	12-Nov-15

When the homes do not provide accurate and timely resident death information, they are compromising a vital function of government, since the Department of Health's Division of Vital Records uses this information as part of a reconciliation to ensure that a death certificate is issued for each death that occurs in the State of Tennessee. Lack of a death certificate could affect a surviving family's ability to settle their deceased relative's estate. Additionally, inaccuracies within the homes' resident records regarding whether a resident was discharged alive or dead could potentially cause difficulties with readmission or billing at a future date.

Recommendation

Executive management should consider establishing formal, documented controls regarding the homes' responsibility to timely and accurately report deaths so the Division of Vital Records can fulfill its responsibilities. Examples of controls that management could consider implementing are

- a documented policy assigning responsibility to a specific staff member or member of management to prepare the monthly death reports;
- a monthly checklist to remind management and staff of the reporting deadline;
- a documented review process to ensure management reviews death information to prevent reporting errors; and
- reeducation as necessary to ensure staff and management understand their responsibilities for documenting accurate information in resident files and reporting accurate and timely information to outside parties.

Management's Comment

We concur. Management notified the administrator at each home of the Division of Vital Records submission date requirement on May 3, 2018, via email. An executive office policy will be developed and approved by November 1, 2018. The policy will identify the TSVHB staff member(s) responsible for submitting the information to the Division of Vital Records by the applicable deadline and the TSVHB staff member responsible for reviewing the information for accuracy.

QUALITY CONTROL

Internal Monitoring

Management must have strong internal monitoring systems in place to identify and correct issues as they arise in order to sustain the best care for residents. We focused our audit work on two areas of the homes' internal monitoring processes: the Quality Assurance Program and the Financial Compliance Officer's work.

Quality Assurance

Title 42, *Code of Federal Regulations,* Part 483, Section 75(a), requires each long-term care facility to implement a Quality Assurance Program. To comply with this guidance, management implemented a quality assurance policy approved on May 13, 2015. The policy established Quality Assurance Committees for each home. These committees meet quarterly, and they are tasked with overseeing five subcommittees: Direct Care, Indirect Care, Administrative, Quality of Life, and Safety. The policy requires each subcommittee to meet monthly.

In addition to establishing a Quality Assurance Program, federal guidance mandates that facilities must maintain documentation supporting the ongoing nature of the program.

Financial Compliance Officer

Along with the monitoring performed by the Quality Assurance Committee and subcommittees, executive management employs a Financial Compliance Officer to review more non-clinical aspects of the homes' operations. The Financial Compliance Officer reports to the Executive Director, who assigns him areas to review. Examples of reviews the Financial Compliance Officer performs include, but are not limited to, Information Technology functions, resident trust funds, and human resources functions. To communicate results, the Financial Compliance Officer produces reports called Executive Summaries, which document and summarize review results for presentation to the Executive Director.

Audit Results

Audit Objective: Did management and staff perform continuous internal monitoring of all locations?

Conclusion: Management established processes for continuous monitoring of the homes' operations; however, the Quality Assurance Committees and subcommittees did not always document minutes for their meetings and did not operate effectively based on our review of the minutes prepared (see **Finding 5**).

Finding 5: The veterans' homes did not ensure that their Quality Assurance Committees and subcommittees fulfilled their responsibilities and duties to help improve operations

Title 42, *Code of Federal Regulations*, Part 483, Section 75(a)(1), requires each long-term care facility to establish a Quality Assurance program. To assist in complying with federal regulations, the Tennessee State Veterans' Homes Board created an "Operations – Quality Assurance" policy. According to this policy, "The Quality Assurance program is an avenue for employees, residents, and families to resolve issues and provide input regarding the quality of care and operational efficiency. By maintaining and improving quality[,] the quality assurance program has a direct impact on the resident's quality of life."

A Quality Assurance Committee and five subcommittees oversee the Quality Assurance program for each home. Without documentation, we could not determine whether the homes held all required committee and subcommittee meetings, or whether the meetings helped the homes achieve operational effectiveness and efficiency.

Quality Assurance Committee Structure

The homes established each subcommittee to identify and address potential issues that could arise during any aspect of service:

1. The *Direct Care subcommittee* should address all hands-on aspects of medical treatment provided, such as medicine distribution and physical therapy.
2. The *Indirect Care subcommittee* should address any other aspects of care that are performed without direct resident interaction but on their behalf with an effect on their direct care; the laundry cleaning service is an example of indirect care services that do not require the resident to be present for them to be performed.
3. The *Administrative subcommittee* should address any potential issues with admission, discharge, or billing.
4. The *Quality of Life subcommittee* should focus on improving and maintaining the resident's quality of life. For instance, this subcommittee would address altercations between residents or between residents and staff that could negatively affect a resident's self-esteem, self-worth, and dignity.
5. The *Safety subcommittee* is responsible for addressing any potential dangers in the home or with the medical equipment.

The homes' internal policy, which was approved May 13, 2015, requires the five subcommittees at each home to meet monthly and then the home's overall Quality Assurance Committee to review all subcommittee meeting minutes quarterly and approve any of the interventions the subcommittees have deemed necessary prior to implementation.

Lack of Committee and Subcommittee Meeting Minutes

To evaluate whether the Quality Assurance Committees and subcommittees were functioning as intended, we requested all meeting minutes from the policy's approval date to April 24, 2018. Based on our calculations, management should have provided minutes for a total of 722 meetings, but they only gave us meeting minutes for 331 meetings (46%). Management was unable to produce minutes for 391 committee and subcommittee meetings (54%). **Table 13** below summarizes the number of required minutes per committee per home, and **Table 14** summarizes the amount of documentation management provided.

Table 13
Required Minutes for Audit Period by Home

Committee	Meeting Frequency	Murfreesboro (5/13/2015 - 4/24/2018)	Knoxville (5/13/2015 - 4/24/2018)	Humboldt (5/13/2015 - 4/24/2018)	Clarksville (1/1/2016* - 4/24/2018)	Total
Quality Assurance Committee	Quarterly	11	11	11	9	**42**
Direct Care	Monthly	36	36	36	28	**136**
Indirect Care	Monthly	36	36	36	28	**136**
Administrative	Monthly	36	36	36	28	**136**
Quality of Life	Monthly	36	36	36	28	**136**
Safety	Monthly	36	36	36	28	**136**
Total		**191**	**191**	**191**	**149**	**722**

*January 2016 represents the first full month the Clarksville home was open.

Table 14
Minutes Provided by Home (5/13/2015 - 4/24/2018)

Committee	Murfreesboro	Knoxville	Humboldt	Clarksville	Total Number of Minutes Provided	Number of Minutes Not Provided
Quality Assurance Committee	11	11	10	7	39	3
Direct Care	24	31	23	19	97	39
Indirect Care	17	26	23	6	72	64
Administrative	25	4	17	6	52	84
Quality of Life	15	7	18	4	44	92
Safety	13	5	0	9	27	109
Total	105	84	91	51	331	391
Total Required (Per Table 13)	191	191	191	149	722	722
% of Total Required	**55%**	**44%**	**48%**	**34%**	**46%**	**54%**

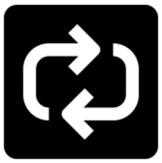
Concerning documentation of meetings, 42 CFR 483.75(a)(1) states,

> The facility must maintain documentation and demonstrate evidence of its ongoing QAPI [Quality Assurance and Performance Improvement] program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities.

In addition, 42 CFR 483.75(d) requires that "the facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained."

Concerns About Quality Assurance Committee Effectiveness to Resolve Operational Concerns

We analyzed all 331 meeting minutes provided to ensure that the issues identified had been corrected. The most predominate concern referenced within the minutes involved the improper sorting of laundry, which resulted in residents' clothing being serially misplaced or lost entirely. The committees in the 4 homes mentioned laundry issues 54 times from January 2015 through the first quarter of 2018. From the minutes provided, we determined that Murfreesboro first discussed issues with sorting laundry in January 2015; Knoxville, in August 2015; Humboldt, in March 2016; and Clarksville, in November 2016. Since the objective of these committees is to identify and resolve potential problems in the home, and such matters remain unresolved in these homes month after month, the effectiveness of the committees appears questionable.



Additionally, several of the minutes reviewed indicated that the meetings only lasted 10 minutes. While there is not a time requirement for meetings, the short duration concerned us due to the committees' objective. One set of the notes showed that only one person attended the meeting for the month. We also noted an instance when one committee voted to only meet quarterly even though it does not have the apparent authority to alter the policy in place. These issues, combined with the lack of documentation of items discussed at meetings, are indications that those responsible for holding the meetings do not fully understand their role.

Explanations Provided

Our discussions with management revealed that they did not collect all meeting minutes before the employees responsible for documentation separated from the homes. Our discussions also revealed that while management believes the Quality Assurance Committee and subcommittee meetings are effective, employees responsible for documenting minutes do not always understand how to complete their task.

Resulting Risks

By not ensuring the Quality Assurance Committees and subcommittees hold and document meetings, and that the committees act as required on decisions made at meetings, management increases the risk that problem areas will persist and potentially cause harm to a resident. Members of these committees are responsible for exercising vigilance in both the identification and resolution of issues in the homes that can have a direct impact on the residents' quality of life.

Recommendation

We recommend that management ensure that each home conducts all required Quality Assurance Committee and subcommittee meetings. Furthermore, management should establish policies to ensure retention of committee meeting minutes regardless of staff turnover. Management should additionally reeducate the members of the established Quality Assurance Committees and subcommittees to promote awareness of their duties, including adequately documenting the meetings and developing and implementing plans to correct ongoing issues identified by the committees. Management should immediately take steps to resolve previously identified issues, especially chronic ones.

Management's Comment

We concur. Tennessee State Veterans' Homes Executive Management has provided and implemented a standard format for meeting minutes as of September 2018 to the homes. The Director of Clinical Reimbursement will review and maintain all federally required Quality Assurance Committee minutes and TSVHB internal subcommittee minutes. The Director of Clinical Reimbursement will also ensure that a resolution is provided, if possible.

Complaints

Despite efforts made, residents and their families will not always be satisfied with every aspect of care provided by the homes, and staff will not always be satisfied with their work environment. It is important that the homes take complaints seriously because not addressing them timely or at all could directly negatively impact the quality of life the homes provide. The homes have four main processes for filing complaints; we focused our work on these methods: Resident Council meetings, two hotlines, and the Social Services Department.

Resident Council

Each of the four homes holds monthly Resident Council meetings, where residents can discuss issues from entertainment options to medication administration times. Each home's activity staff generally oversee these meetings. Information about the council is included in the admissions and welcome packet for each of the homes (see **Figure 20**).

Figure 20
Excerpt From Resident Admissions and Welcome Packet

> You are invited to join and participate in the TSVH resident/family council. The sole purpose of the Council is to improve the lives of TSVH residents and to support their family and friends. The Council is the eyes, ears, and perhaps most importantly, the voice of the residents who can no longer speak for themselves. The resident council usually meets on a monthly basis. There is a time at every meeting to express concerns or make a suggestion about the TSVH or the residents. The administrator may be invited to make a report about current issues and future plans for the TSVH and to hear any concerns and suggestions.

The council documents meeting minutes. Additionally, activity staff forward any complaints to the appropriate departments (for example, nursing, dietary, or maintenance) via the Resident Council Concern Response form, which lists the department that the concern involves, the concern itself, management's resolution to the concern, and the signature of the home's administrator and the involved department's supervisor.

Hotlines

The homes operate two hotlines people can used to file complaints against the homes: the CareLine and the Compliance Hotline:

- CareLine – Since 2015, management has provided the CareLine, which receives concerns about resident care and employee working conditions. The Executive Assistant is responsible for documenting incoming CareLine calls on a log and forwarding complaints to the Executive Director, who then passes the complaints along to the member of management best equipped to handle them. For example, if someone called in to report a concern about a specific home, the Executive Director would notify the Administrator for that home. Once management has handled the complaint, the Executive Assistant documents the resolution and closure date on the log.
- Compliance Hotline – Established by management in 2013, the Compliance Hotline is intended for financial complaints, fraud, and other issues not involving quality of care. The Financial Compliance Officer, who reports to the Executive Director, records the calls this hotline receives on a log separate from the one used to track CareLine calls, follows up on the calls, and documents their closure.

Social Services Department

Residents also have the option to report complaints to the Social Services Department. Many of these complaints consist of issues such as missing or broken personal items, which the Social Services Department investigates directly. The department may forward complaints involving other matters to the respective departments within the home. Each home has a log to document complaints made to the Social Services Department and their resolution.

Audit Objective: Did management have processes in place to accept and timely address complaints from residents, their families, and staff?

Conclusion: Management had processes in place to accept and address complaints; however, management did not always document the follow-up or closure of the complaints (see **Finding 6**).

Finding 6 - The homes did not have comprehensive policies in place for documenting, addressing, and monitoring the resolutions of complaints received from residents and employees

The successful operations of the Tennessee State Veterans' Homes are highly dependent upon the services provided to the satisfaction of the residents and their families. Home residents and their families have multiple processes to submit a complaint to management regarding any facet of the resident's life including resident care, living conditions, daily meals, and missing personal items. The homes' complaint processes also include ways for current or former employees and the general public to submit complaints regarding issues ranging from employment practices to possible fraudulent activities.

Our testwork disclosed, though, that management had not established policies for investigating, documenting, and resolving the various complaints received through the CareLine, the Compliance Hotline, Resident Council meetings, and the Social Services Department.

Deficiencies Noted

CareLine, Compliance Hotline, and Resident Council

Title 42, *Code of Federal Regulations*, Section 483.12 (c), which pertains to long-term care facilities, states, "In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must . . . (2) have evidence that all alleged violations are thoroughly investigated." Furthermore, best practices for hotlines from publications such as the *Journal of Accountancy* suggest maintaining an audit trail that documents the complaint, person assigned to investigate, actions taken, and the final resolution, including dates.

Examples of Complaints Missing Details of Response

- Daughter concerned about mother's care – The Executive Director attempted once to return the daughter's call.
- Unspecified complaint about the Clarksville home – The hotline log merely states that the Executive Director and another staff member called the complainant back.
- Complaint about employee treatment – The hotline log only specifies that the Executive Director met with the employee.

We tested the entire population of 52 Careline calls received from July 1, 2015, through February 8, 2018, and 10 Compliance Hotline calls received from February 18, 2015, through January 31, 2018, for a total of 62. Additionally, we reviewed all the Resident Council meeting minutes for the four homes for the period January 2015 through March 2018 to determine whether management reviewed complaints properly and timely. Based on testwork performed,

- since management did not document actions taken in response to 16 out of 62 calls received (26%), we could not determine whether the complaint was adequately reviewed;
- for 23 of the 62 calls received (37%), management did not document the date they closed the complaint, and therefore, we could not determine whether the complaint was reviewed timely; and
- Humboldt management did not adequately document steps taken to investigate complaints provided during Resident Council meetings.

Deficient Humboldt Resident Council Complaint Resolutions

The minutes had no resolution listed for 2018 complaints such as cold food, bed pans not being cleaned, desire for more activity outings, not getting showers, and call lights not being answered in a timely manner.

Social Services Department

The homes' "Grievance Policy" states,

> The Social Services Department will keep a current log of all resident grievances which will include the resident name, date, nature of grievance and the resolution of the grievance. The log will also include the date and time the resolution was reported to the resident.

Based on our review of complaints (grievances) made to the Social Services Department from January 2015 through the most current available (March 2018 for Humboldt, April 2018 for Murfreesboro and Knoxville, and May 2018 for Clarksville), we determined that

- staff in the Murfreesboro, Humboldt, and Knoxville homes did not document any of the dates and times when they informed residents of the resolution of their complaint, while Clarksville staff did not include this information in 4 of 57 instances in 2017 (7%);
- Humboldt staff did not maintain the complaint logs for six months (January 2015, November 2015, December 2015, April 2016, June 2016, and July 2016); and

- Clarksville staff did not document the resolutions of 5 of 75 complaints in 2018 (7%), all involving laundry concerns.

Explanation for Deficiencies

According to management, the problems we identified arose as a result of lack of consistency in the homes' documentation maintenance practices, a lack of monitoring of complaints, and a lack of policies and procedures in the case of the hotlines.

Repercussions of Deficiencies

Without documenting the resolution of complaints through all channels available to residents, family members, and staff, management does not have evidence of fulfilling federal, state, or internal requirements. Additionally, the absence of a documented follow-up with residents and staff regarding the resolution of complaints could contribute to sub-par care for residents or at least negative perceptions of the level of care residents receive.

Recommendation

Management should

1. develop policies and procedures to establish consistent requirements for documenting, reviewing, and resolving resident, family, and staff complaints received through the CareLine, Compliance Hotline, and Resident Council meetings;
2. monitor staff to ensure they properly document complaints and the resolutions received through these channels, as well as through the Social Services Department; and
3. ensure that staff take proper measures to maintain documentation supporting efforts to resolve complaints.

Management's Comment

We concur. Management is in the process of developing procedures to establish consistent requirements for documenting, retaining, reviewing, and resolving resident, family, and staff complaints received through the CareLine, Compliance Hotline, and Resident Council meetings. The procedures will be approved and implemented by December 1, 2018. Management will perform random monitoring periodically to test compliance.

Corrective Actions

The Centers for Medicare and Medicaid Services (CMS), the State of Tennessee Department of Health, and the U.S. Department of Veterans Affairs (VA) each conduct external reviews, called surveys, of the Tennessee State Veterans' Homes to ensure the homes meet their criteria for operating efficiently, effectively, and safely. For example, state representatives conduct surveys in accordance with Section 68-11-210, *Tennessee Code Annotated*. When federal agencies conduct surveys,

they use Title 38, *Code of Federal Regulations* (CFR), Section 51.60 - 51.210, which outlines VA's expectations for the care that veterans receive in nursing homes, and 42 CFR 483.1 – 483.95, which outlines CMS's expectations for standards of care provided in long-term care facilities.[11]

If the external agencies detect instances of noncompliance with the standards they are reviewing, the agency issues a survey with deficiencies noted. The staff at the nursing home where the survey is conducted respond to the deficiencies with a corrective action plan and corresponding completion date. If the homes do not implement their corrective action timely, they could be subject to consequences including monetary fines or even the facility's closure.

Audit Results

Audit Objective: Did management develop and implement corrective actions plans in response to deficiencies identified by state or federal surveys?

Conclusion: Management did implement proposed corrective actions in response to deficiencies identified.

HUMAN RESOURCES

The Tennessee State Veterans' Homes employees are integral to the homes' mission of providing quality long-term care and rehabilitative services to Tennessee's veterans and other residents. As of April 16, 2018, there were 1,932 total employees including executive management. Of critical importance are the approximately 1,400 direct care providers, those staff who are closest to the residents, including nurses and certified nursing assistants.

The homes' Director of Risk Management, a member of the executive management team, oversees the homes' Human Resource function. Each of the four homes has a Human Resource Director who reports to the Director of Risk Management. The Director of Risk Management additionally serves as the homes' coordinator to ensure compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving federal financial assistance.

The homes' Human Resource Directors are responsible for hiring new staff. Among these responsibilities is the screening of potential employees to ensure they are both qualified and that the residents will be safe in their care. These screening procedures cover criminal background and registry checks, drug screens, and verification of any required professional licenses. New volunteers are also required to undergo screening similar to that of new employees. Furthermore, the Human Resource Directors have responsibility for termination procedures,

[11] Based on the deficiencies noted in survey reports, CMS's objectives were broader than our testwork objectives. For example, CMS closely reviews areas such as food service, hygiene, and building maintenance; we did not include those areas in our testwork.

which encompass performing exit interviews with separating staff to learn ways to improve the working environment.

Prior Audit Results

The March 2009 sunset performance audit of the board noted high turnover among staff and a lack of formal documented analyses to determine its cause, including a lack of a consistent exit interview process at two of the homes. The September 2012 sunset performance audit report contained similar findings. The 2014 sunset performance follow-up audit found that

- while the homes were now producing turnover reports in a consistent format, the Human Resource Directors were not involved in producing the reports; and
- the formula the homes used to produce the turnover rates was not the formula that could be produced by the homes' Automatic Data Processing (ADP) system, which is also the more professionally accepted formula for calculating turnover rates.

The March 2009 and September 2012 performance audits further revealed that the homes did not monitor contractors that provided direct care to residents for their compliance with Title VI requirements. According to the 2014 follow-up report, while management had created a mechanism in the form of a self-survey to monitor contractors' compliance with Title VI requirements, the board was not involved in creating this tool. Additionally, the homes did not ensure that all contractors returned the self-survey by the annual deadline.

Audit Results

1. **Audit Objective:** Was each resident's staffing plan fulfilled?

   Conclusion: Based on discussion with the Director of Clinical Services and the Finance Director, along with review of federal and state regulations, the homes assign an equal amount of staff to designated areas of each home rather than creating a staffing plan based on individual resident needs. Our sample testwork disclosed that the homes met the federal and state minimum staffing levels of direct care providers. The homes could not provide documentation, however, that a Registered Nurse was always on duty as required by federal regulations (see **Finding 7**).

2. **Audit Objective:** Did management correct the finding regarding Title VI compliance in the November 2014 performance audit by monitoring subrecipients or any contractor/agent that delivered direct care to residents, and was the board involved in Title VI monitoring oversight?

   Conclusion: While the finding was partially resolved because the board discussed and approved a policy for Title VI monitoring of contractors, management did not ensure that all contractors complied with the policy by returning a self-survey (see **Finding 8**).

3. **Audit Objective:** Did management perform required pre-employment screenings, including background checks, registry checks, licensure verifications, and drug screens?

   Conclusion: We found that management did not perform required pre-employment screenings timely or at all. Additionally, management did not ensure that contractors who provide direct care to residents conducted screening of their staff as required by state statute and regulations (see **Finding 9**).

4. **Audit Objective:** Did management perform required screenings of volunteers?

   Conclusion: Management did not maintain a formal policy defining either the activities meeting the definition of a volunteer or the screening process for volunteers, although management stated that the practice was for new volunteers to be subjected to the same screening as new employees. Based on testwork performed, management did not follow their unwritten policy to screen all new volunteers and could not provide documentation that others were screened in a timely manner (see **Finding 10**).

5. **Audit Objective:** Did management correct the finding regarding turnover in the November 2014 performance report by using the correct formula when calculating staff turnover rate reports and involving the homes' Human Resource Directors in the production of the staff turnover reports and monitoring of staff turnover rates?

   Conclusion: Management corrected the finding regarding turnover in the November 2014 performance report by using the correct formula when calculating staff turnover rates. Although the periodic turnover reports are still produced by the Finance Director, this appears to be a reasonable decision so that executive management and the board can monitor turnover rates for the homes across the state.

6. **Audit Objective:** Did staff turnover and vacancy rates compare favorably with industry standards?

   Conclusion: We did not identify a leading industry standard of long-term care facility turnover rates. Based on studies we reviewed, high turnover is a consistent issue in the long-term care industry. The homes' fiscal year 2016 and fiscal year 2017 annual turnover reports showed that high turnover continues to be a concern (see Observation 2).

7. **Audit Objective:** Did management conduct exit interviews of separating employees to determine the reasons for their departure and then address any concerns raised?

   Conclusion: Although management mailed surveys to former staff's homes, management did not consistently conduct personal exit interviews of separating employees to determine the reasons for their departure and then address any concerns raised (see Observation 2).

Finding 7: The veterans' homes did not document the presence of a Registered Nurse on staff at all times

The Tennessee State Veterans' Homes provide direct care and rehabilitation for Tennessee's veterans. According to federal and state regulations, the homes must maintain a Registered Nurse (RN) on duty at all times. While performing our testwork, though, we found that the homes could not provide evidence they had met this requirement.

Applicable Regulations

According to Title 38, *Code of Federal Regulations*, Part 51, Section 130(b), "The facility management must provide registered nurses 24 hours per day, 7 days per week."

Also, Chapter 1200-08-06-.06(4)(a) of the *Rules of the Tennessee Department of Health* states,

> Each nursing home must have an organized nursing service that provides twenty-four (24) hour nursing services furnished or supervised by a registered nurse. Each home shall have a licensed practical nurse or registered nurse on duty at all times and at least two (2) nursing personnel on duty each shift.

Testwork Results

We performed testwork to determine whether the homes had maintained adequate staffing levels. We selected a random sample of 60 dates (15 dates randomly selected for each of the 4 homes) for the period January 1, 2015, through March 31, 2018, a total population of 1,186 dates.[12] For each date selected, we tested employee timecards and resident census data to ensure that the home had the proper level of direct-care nursing staff and a Registered Nurse available at all times. While we did not identify any deficiencies in direct-care nursing staff levels, we discovered that the homes had gaps in RN coverage for 14 of the 60 dates tested (23%).

We identified RN coverage gaps ranging from 8 minutes to nearly 7 hours, with an average of 55 minutes.

Reason for RN Coverage Gaps

The Finance Director explained that manager-level RNs do not document actual hours worked. Because these RNs are salary-exempt, they will not be paid beyond a set number of hours each week. Since RNs will not be paid for the time, they do not track the hours worked past the hours for which they will be paid. The Finance Director provided schedules in some instances to show that salaried RNs were scheduled to work during the gap times; however, this was not adequate documentation that an RN was actually at work. Management also provided

[12] The Clarksville home opened in December 2015. Therefore, the period tested for the Clarksville home was December 1, 2015, through March 31, 2018, for a total population of 852 dates.

documentation from the patient record management system showing both login/logout times and some individual time-stamped system transactions that occurred during the gap times. We made adjustments to our testwork for the time period that the documentation indicated an RN was logged into the system. We determined that this was not, however, adequate documentation to show that the RNs had actually been on duty during the entire time in question.

Recommendation

Management should ensure that actual hours worked for RNs are documented to provide evidence that the homes maintained required coverage 24 hours per day, 7 days per week.

Management's Comment

We concur in part. We concur that we do not require salary-exempt employees including RN nurses to document actual time worked. We do not concur that adequate documentation was not provided to show RNs had actually been on duty during the entire time in question. Three of the 14 were due to the RN nurse inadvertently selecting the time in/out button instead of the lunch button on the timeclock when she went to lunch. Tennessee law (TCA 50-2-103(2)(A)(B)) requires employers to provide a 30-minute meal break to employees who are scheduled to work at least six consecutive hours. Management provided master staffing sheets, emails, login/logout times of patient record management system for dates and times requested. In addition, nursing staff must report off to the incoming nursing staff before they leave. Leaving prior to coverage may be considered abandonment and reflected on a nurse's license per Tennessee Board of Nurses Rules for Registered Nurses 1000-01-.13 Unprofessional Conduct.

Auditor's Comment

The documentation provided by management such as emails and computer system login/logout times only showed an RN on duty at sporadic times and was not sufficient evidence to support the entire workday in question. In addition, the master staffing sheet illustrated that an RN was *scheduled* to work in advance but did not provide evidence that the RN was actually on duty during those scheduled times. Without clear evidence (for example, the employee timecards or a sign in/sign out sheet), we were unable to determine when the RNs had arrived for, or departed from, work.

Finding 8 – The homes' management still did not properly monitor contractors that provide services to residents for compliance with Title VI requirements

Background

Title VI of the Civil Rights Act of 1964 prohibits discrimination under federally assisted programs on the basis of race, color, and national origin. The U.S. Department of Justice's *Title VI Legal Manual* states in part: "A recipient may not absolve itself of its Title VI obligations by hiring a contractor or agent to perform or deliver assistance to beneficiaries. . . . Title VI may cover a contractor that performs an essential function for the

recipient, making the contractor itself a recipient." The Tennessee State Veterans' Homes Board contracts with medical providers that provide care to residents, such as therapy services.

Performance audits dated March 2009 and September 2012 included findings that the board did not monitor its contractors for Title VI compliance. The 2012 report stated, "The attestation implied by a contractor's signature on a contract that the contractor will comply with standard state contract clauses regarding nondiscrimination is insufficient. The state agency must develop a monitoring mechanism that routinely confirms compliance with contract requirements in general and Title VI requirements in particular." The 2012 audit recommended

- that the board direct the Title VI coordinator to conduct Title VI compliance reviews of all its contractors that provide services to residents on the board's behalf; and
- that the board develop a monitoring mechanism that routinely confirms and documents compliance with contract requirements.

In March 2013, the board stated in its six-month follow-up to the audit that

- the Title VI coordinator will include a Title VI component in its contract monitoring by June 30, 2013; and
- a monitoring questionnaire had been developed and distributed to all contractors providing services to residents on the board's behalf and that it would be part of the annual update to vendor records.

A performance audit follow-up report dated November 2014 indicated that the 2012 finding had been partially resolved but with a new issue detected. Specifically, regarding the unresolved issue, the 2014 report noted that there was no involvement by the board in creating a monitoring mechanism and directing the Title VI coordinator to implement Title VI monitoring of all contractors providing services to residents on the board's behalf. The newly discovered issue concerned the fact that board staff did not ensure that all contractors completed and returned the Title VI self-survey by the annual deadline of July 31.

Current Audit

We followed up on the existing issues from the prior audit reports, and our testwork revealed the following:

- The board did approve a formal policy requiring the use of self-surveys to be obtained from contractors pertaining to their compliance with Title VI.

- Management has still not ensured that all contractors returned a self-survey, and that corrective action was taken when the self-surveys were not returned. From a population of 96 self-surveys required to be completed by direct care providers for the period January 1, 2015, through June 30, 2017, we found that 8 of 63 surveys tested (13%) were not returned by the direct care provider to the homes and that

for all 8 surveys not returned, management had taken no corrective action against the contractor.

The Director of Risk Management, who serves as the Title VI coordinator, told us that some contractors would not respond to multiple requests to return the self-surveys. Additionally, she stated that a request to add language specifically requiring the return of the surveys to the contracts had been denied by the Department of General Services' Central Procurement Office (CPO). She also noted that contractors that provide care to residents are monitored for compliance because there is always a staff member of the homes in the area when service is provided. Toward the end of our fieldwork, the Director of Risk Management sought and obtained approval from the CPO to include language in the contracts requiring the return of the self-survey.

Because management did not ensure that all self-surveys were returned, management failed to comply with internal policy and, more significantly, had no evidence that they met the requirements of Title VI.

Recommendation

Management should ensure that

1. the homes' contracts contain the Title VI self-survey language; and
2. contractors either return the Title VI self-survey as required or face timely corrective action upon failure to comply.

Management's Comment

We concur. Title VI self-survey language is being added to all contracts involving the provision of direct care to residents. Management will continue to make repeated efforts to obtain the completed self-surveys and advise contractors that they risk corrective action for failure to comply.

Finding 9: The veterans' homes did not perform the following checks on all employees, including those providing direct care to veterans: criminal background, abuse registry, sex offender registry, drug screening, tuberculosis, and reference

The Tennessee State Veterans' Homes provide direct care and rehabilitation for veterans. Given the vulnerable population served, federal, state, and internal regulations require employees to undergo a series of pre-employment screenings to ensure residents' safety and well-being.

While performing our testwork, we found that the homes did not always obtain the mandated criminal background, registry, health, and reference checks. We also discovered that the homes did not have a process to ensure that contractors providing direct care to residents obtained background checks for their employees.

Governing Guidelines

Guidelines for pre-employment screenings originate at the federal, state, and home level as follows:

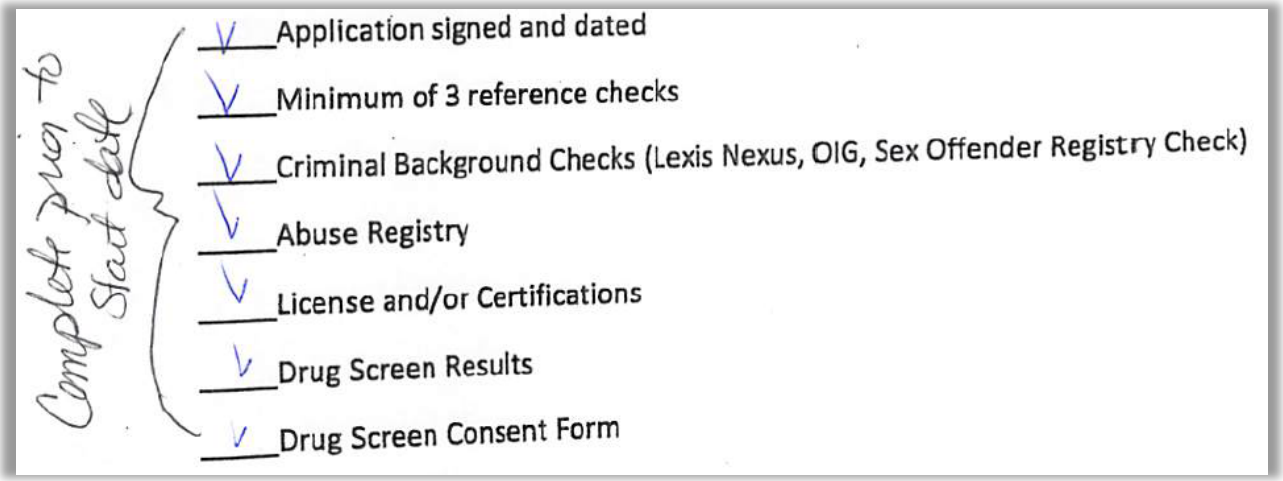
- According to Title 38, *Code of Federal Regulations*, Part 51, Section 210, "Professional staff must be licensed, certified, or registered in accordance with applicable State laws." This federal regulation also states that facility management must verify staff members' licensure, certifications, and experience.

- Section 63-1-149, *Tennessee Code Annotated*, specifies that if a background check for an individual is not completed prior to employment, then sex offender and abuse registry checks must be performed.
- The Tennessee Department of Health's *Standards for Nursing Homes,* Rule 1200-08-06-.04, states that "[a]ll nursing homes shall initiate a criminal background check on any person who is employed by the facility in a position which involves providing care to a resident or patient, prior to or within (7) days of employment." The department additionally calls for homes to check employees' work and personal references, licenses, and education and training records.
- The Department of Health's standards add that

  > Criminal background checks are also required by any organization, company, or agency that provides or arranges for the supply of direct care staff to any nursing home licensed in the state of Tennessee. Such company, organization, or agency shall be responsible for initiating a criminal background check on any person hired by that entity for the purpose of working in a nursing home, and shall be required to report the results of the criminal background check to any facility in which the organization arranges the employee to work, upon request by a facility.

- The homes' *Compliance Program* policy for employee screening requires criminal background checks; previous employment verification; pre-employment and annual license verification; checks of the Office of Inspector General List of Excluded Individuals and Entities prior to hire and monthly; State of Tennessee abuse registry checks; and drug screenings.
- The description of the application process on the homes' website additionally includes a tuberculosis skin test requirement.
- In order to ensure completion of applicable pre-employment screening, the homes use a new hire checklist. See **Figure 21**.

Figure 21
Excerpt From New Hire/Audit Checklist for Personnel Files*



*Notations added by management.

Testwork Results

Home Employees

We tested two samples, one for employees hired at the homes during our audit scope period and one for individuals employed during our scope period but hired prior to our scope start date:

1. Hired During Audit Scope Period – From the population of 1,320 individuals hired at the homes from January 1, 2015, through April 16, 2018, we selected a random, nonstatistical sample of 25 to test whether the homes had completed applicable screenings prior to their start date.
2. Hired Before Audit Scope Start Date – We obtained the population of 611 individuals hired at the homes prior to January 1, 2015, and then selected a random, nonstatistical sample of 25 to test whether the homes had completed applicable screenings at some point.

We present our testwork results in **Table 15**.

Table 15
Pre-employment Screening Problems Identified

Condition	Error Rate for Employees Hired During Audit Scope Period	Error Rate for Employees Hired Prior to Audit Scope Start Date
The homes did not properly perform one or more pre-employment screenings, as detailed below	**4 of 25 (16%)**	**5 of 25 (20%)**
Did not obtain criminal background check	2 of 25 (8%)	2 of 23 (9%)**
Did not conduct check of National Sex Offender Public Website	2 of 2 (100%)*	2 of 2 (100%)*
Did not conduct check of the Tennessee Bureau of Investigation's sex offender registry	2 of 2 (100%)*	2 of 2 (100%)*
Did not conduct check of Tennessee Department of Health's abuse registry	-	2 of 2 (100%)*
Did not obtain drug screening	1 of 25 (4%)	3 of 25 (12%)
Completed two reference checks instead of the required three	2 of 25 (8%)	-
Did not conduct tuberculosis test	-	2 of 25 (8%)

*Unlike for the other 23 employees, the homes did not receive the completed criminal background check prior to these 2 employees' hire dates. Therefore, in accordance with Section 63-1-149, *Tennessee Code Annotated*, the homes were required to perform separate sex offender and abuse registry checks before the employees' start dates.
**For two employees in our sample, the hire date was prior to the effective date of the requirement for background screenings (October 1, 2010). As a result, we only tested 23 employees.

When we performed the registry checks ourselves, we did not identify any employees who had sex offender or abuse violations.

Contractor Employees

Based on inquiry with the Director of Risk Management and an examination of direct care provider contracts, we determined that the homes did not have a process to ensure that contractors were aware of the requirement to conduct background checks on any staff who provide services to residents. Our sample testwork[13] revealed that while some of the contracts the homes had with direct care providers contained language requiring the performance of background checks, the majority (35 of 41, or 85%) did not.

[13] We obtained from management populations of contracts the homes had with direct care providers that were in effect during fiscal years 2015, 2016, and 2017, and we combined the populations. We then selected a random, nonstatistical sample of 60. We later identified an additional contract in effect for all 3 years that the original population from management did not include and decided to add those to our sample, for a total of 63 contracts. Since 22 of the contractors appeared in our sample multiple times (for contracts covering multiple years), we excluded those and ended up with 41 to test.

Explanation for Problems Identified

When we questioned the Director of Risk Management about the issues we found, she advised us that the homes' management has trained Human Resources staff and provided them with a binder containing pertinent regulations, including a new hire checklist. Our testwork results revealed, though, that in 5 of 25 cases (20%), the homes did not complete the new hire checklist before the employee's start date.

The Director of Risk Management believed that Human Resources personnel may not have followed applicable regulations (such as finishing the checklist) because they were overwhelmed by the demands of processing new hires, as the homes' turnover rates are high.[14] For the instances where the homes could not produce a criminal background check completed prior to hire (which triggered the requirement for separate sex offender and abuse registry checks), she asserted that the background checks had been completed; however, the homes had not followed correct recordkeeping procedures. A complicating factor is that in October 2014 the homes changed the vendor contracted to perform background checks; therefore, the homes no longer had access to archived checks.

The Director of Risk Management told us that it was not the homes' responsibility to ensure that contracted direct care providers performed background checks, since the language of the Department of Health's rule assigned the responsibility to perform the background check to the contractor. Since our audit inquiry began, the Director of Risk Management has obtained approval from the Central Procurement Office to add language to all direct care provider contracts requiring the performance of a criminal background check.

Effects of Noncompliance

Without using the screening techniques prescribed by federal and state laws and regulations, the homes may hire an unsuitable individual, thereby placing residents at risk for sub-par care and injury or even abuse and neglect.

Examples of Positions With Access to Residents

- various nurses and nursing assistants
- dietary workers
- housekeepers

Recommendation

The homes should use the new hire checklist to ensure they perform all necessary screenings and verifications prior to hiring employees. Furthermore, the Director of Risk Management should schedule training to ensure Human Resources personnel properly understand related laws, regulations, policy, and procedures. As a follow-up measure, she should also perform random monitoring periodically to test compliance.

In addition, the homes should ensure that all provider contractors are aware of the requirement to conduct background checks on staff who will provide direct care in the homes, and the Director of Risk Management should consider periodically obtaining a sample of the background check results to ensure provider contractors' performance.

[14] We discuss the homes' high turnover rates further in Observation 2.

Management's Comment

We concur. Human Resource personnel were retrained on July 12, 2018, to ensure they perform the necessary screenings and verifications prior to hiring employees and to ensure they understand the underlying laws, regulations, and policies. Management will perform random monitoring periodically to test compliance. Language is being added to all contracts involving the provision of direct care to residents restating the statutory requirement for criminal background checks for staff who provide direct care in nursing homes.

Finding 10: The veterans' homes lacked internal controls over volunteers

The Tennessee State Veterans' Homes use not only employees but also volunteers to enhance the lives of residents. While performing testwork, we identified two primary concerns surrounding the screening of volunteers who interact with veterans. Specifically, we found that the homes did not

- develop a formal policy to define volunteers or to codify the screening required; or
- follow their own stated intentions and informal volunteer screening process, which included performing criminal background, sex offender and abuse registry, drug screening, and health checks.

Lack of Volunteer Guidelines

Based on conversations with management, we found that the homes' screening process for volunteers mirrors the process for employees.[15] Volunteers must apply; be interviewed by the Activities Director at the home where they wish to volunteer; and pass a criminal background check, registry checks, drug screening, and tuberculosis skin test before beginning volunteer service. The homes implemented a Volunteer Orientation Checklist as a control to ensure the proper execution of the screening process. The homes' Human Resources personnel told us that it was their practice to require completion of the checklist before approving the volunteer for service.

Despite taking these measures, the homes have not developed a formal volunteer policy to ensure consistency of the screening process to promote safety for resident veterans. Consequently, the Human Resources personnel at the homes used different methods to define who and what services qualified as volunteering. See **Table 16**.

[15] For more information about the homes' employee screening procedures, see **Finding 9**.

Table 16
Inconsistent Volunteer Definitions Offered by Human Resources Personnel at Each Home

Home	Volunteer Definition
Murfreesboro	The Murfreesboro home only has two volunteers. Volunteers are more likely to have one-on-one contact with residents and possibly be left alone with a resident, which would be cause for the individual to be screened. Volunteers give of their time without pay and more than once. If individuals come for an activity and are "monitored" by the Activities Department and other staff, the home considers them to be entertainment and does not screen them as volunteers.
Humboldt	Humboldt does not really have anyone who comes in regularly to volunteer. They have some individuals who come in and visit the residents and drink coffee; they call them "coffee drinkers." The coffee drinkers only come when they get a day off. These individuals do not provide a service for the facility or the residents. To be classified as volunteers, individuals would come on a routine basis, maybe a few days a week. Volunteers must be at least 18 years of age.
Knoxville	A volunteer is someone who gives his or her time and energy without pay. Individuals or groups do not have to come a certain number of times to gain volunteer status. The home has groups that come in to sing, but these individuals are considered entertainment rather than volunteers.
Clarksville	An individual will request to be a volunteer to provide a service without pay. To be classified as a volunteer, the individual usually has to come more than once, although there is not a specific number of times. Most of the time, volunteers dedicate a certain day of the week or month to come to the home.

Also due to the lack of policy, we noted that the homes did not uniformly complete the volunteer screening, including the volunteer checklist.

Volunteer Screening Not Completed

From each home, we requested the population of individuals that management had considered volunteers for the period January 1, 2015, through February 28, 2018, which totaled 35 individuals (1 at Murfreesboro, 0 at Humboldt, 1 at Knoxville, and 33 at Clarksville). We then selected a random, nonstatistical sample of 25 volunteers to test. After we selected our sample, management alerted us to the existence of another volunteer at the Murfreesboro home; we added him to our sample, for a total of 26 volunteers tested.

We found deficiencies in the screening for 25 of the 26 volunteers tested (96%). Specifically,

- The homes performed the following screenings, but due to missing dates, we could not determine whether they were performed prior to the volunteer beginning service:

    - 22 criminal background checks;
    - 17 tuberculosis tests; and
    - 22 drug screenings.
- In other instances, the homes did not perform the following screenings at all:
    - 3 criminal background checks or, as an alternative,[16] sex offender and abuse registry checks;
    - 8 tuberculosis tests; and
    - 3 drug screenings.

Furthermore, we identified 15 volunteer checklists that the homes did not date-stamp to indicate approval and 10 checklists that the homes did not fully complete.

Effects of Deficiencies Noted

Principle 10.02 of the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* states,

> Management designs control activities in response to the entity's objectives and risks to achieve an effective internal control system. Control activities are the policies, procedures, techniques, and mechanisms that enforce management's directives to achieve the entity's objectives and address related risks. As part of the control environment component, management defines responsibilities, assigns them to key roles, and delegates authority to achieve the entity's objectives.

Since the homes lacked adequate controls, management and staff did not consistently screen volunteers. Without clear guidance defining who should be classified as a volunteer and what level of screening is necessary, the residents' health and safety are jeopardized, especially when outside individuals are allowed to interact with residents alone—even when this unsupervised interaction occurs only once.

Management agreed that the absence of a formal volunteer policy left too much room for interpretation. Following discussions with us, management held a meeting on June 20, 2018, to develop a formal policy that defines volunteers and establishes a screening process. Executive Office management also plans to start training the homes' management and staff.

Recommendation

Executive Office management should proceed with its plan to develop a formal, comprehensive volunteer policy and train the homes' management and staff. In addition,

[16] According to Section 63-1-149, *Tennessee Code Annotated*, if an agency does not complete a background check for an individual prior to employment, then the agency must perform sex offender and abuse registry checks.

Executive Office management should monitor the homes' compliance with the new volunteer policy.

Management's Comment

We concur. A formal policy that defines volunteers and establishes a screening policy was approved on June 20, 2018, and was implemented by the homes' management and staff immediately. Management will monitor the homes' compliance with the new policy periodically.

Observation 2 – The board and management should continue to seek ways to reduce the turnover rate of staff who provide direct care

The Tennessee State Veterans' Homes continue to suffer from a high turnover rate in some key positions. (See **Table 17**.) Namely, the turnover for Certified Nursing Assistants (CNAs) who provide direct care to residents remains high.

Both the Director of Risk Management and the Murfreesboro Human Resource Director indicated in our discussions that the high turnover causes the homes' Human Resource Directors to spend a great deal of time on recruiting and onboarding new staff members. According to the Finance Director, collectively the homes currently spend over $70,000 annually on advertising and recruiting. In addition, based on statistics obtained from the homes, we calculated that approximately $22,000 was spent in calendar year 2017 alone for new employees' screening.

From 2016 to 2017, the CNA turnover rates at the homes ranged from 58% to 106%.

Based on research performed, high turnover rates are a consistent problem in the personal care industry. Studies have shown that high turnover rates of direct care providers including CNAs and nurses contribute to an overall decline in resident health. Factors that can contribute to employee turnover in the industry include relatively low compensation as well as a poor general working environment. The Director of Risk Management (who oversees each home's Human Resource Director) believes that a competitive job market is to blame for the homes' high turnover rates among certain types of staff. She indicated that when wages for various positions are compararable to those in other industries, such as restaurant or retail, staff may choose to go where the job is less strenuous than caring for residents.

Steps Taken to Reduce Turnover

The board and management have taken steps to attempt to mitigate the high turnover in direct care positions. The board approved a budget that gave all employees a 2% cost of living increase that took effect in January 2018. In addition, the employee positions for CNA, Dietary Aide, and After-hours Receptionist received a $1.00 per hour increase in wages, while Housekeeper and Laundry Aide positions received a $.50 per hour increase. This brings the CNA hourly rate to $11.22 per hour. Furthermore, the Director of Risk Management and the

Finance Director said that future bonuses were being considered based on incentives for employee compliance such as having the fewest absences or avoiding disciplinary action.

Lack of Exit Interviews

We did note one area where the homes could do a better job engaging with staff and analyzing the reasons for their departure. The homes' Employee Handbook states that all separating employees are expected to have a "confidential" exit interview "in order to determine ways we might continue to improve working conditions." We obtained a population of 346 employees who voluntarily resigned or retired during the period January 1, 2015, through May 11, 2018. We selected a random sample of 25 of these employees to determine if an exit interview had been performed. For all 25 employees (100%), we were unable to verify that an exit interview had been performed. According to the Director of Risk Management and the Finance Director, this is because most exit interviews are only mailed to former employees' homes and the ones that are returned are sometimes returned anonymously. They also stated that because of high turnover, Human Resource Managers had a hard time keeping track of all the exit interviews to be performed. They pointed out that they had attempted to obtain feedback from current employees through an annual anonymous survey as well.

Recommendation

Management should emphasize that exit interviews are to be scheduled and performed for all applicable employees. The interviews should be structured so that management obtains information that can be used to determine why employees are leaving and what actions could be taken to mitigate turnover. In addition to the exit interviews, management should consult other states for ideas that could be used to help with the turnover problem. Management should also continue to seek other ways to engage with staff to identify any further actions that might reduce the turnover rates, in order to ensure that the quality of care for residents remains as high as possible.

Table 17
Turnover Rates by Home

	Clarksville		Humboldt		Knoxville		Murfreesboro	
Job Title	2016	2017	2016	2017	2016	2017	2016	2017
Activities Assistant	-	67%	40%	29%	57%	0%	107%	156%
Activities Assistant Director	-	-	0%	0%	0%	0%	0%	133%
Activities Director	0%	0%	0%	0%	0%	0%	200%	0%
Admissions Director	0%	200%	0%	0%	0%	0%	67%	0%
After Hours Receptionist	100%	0%	0%	0%	200%	133%	0%	0%
Assistant Director of Nursing	-	-	0%	-	0%	0%	0%	100%
Assistant Dietary Manager	-	0%	0%	200%	0%	0%	-	-
Assistant Environmental Supervisor	-	-	-	-	0%	200%	-	-
Central Supply Clerk	0%	0%	-	0%	0%	0%	-	-
Clinical Dietary Manager	-	-	-	-	0%	0%	0%	0%
Clinical Reimbursement	-	-	-	-	-	-	0%	-
CNA/CNT	75%	106%	63%	60%	58%	92%	102%	102%
CNA/CNT - Activities	-	200%	0%	55%	40%	0%	0%	33%
CNA Central Supply Clerk	-	-	0%	200%	-	-	0%	0%
CNA/CNT - Hydration	-	-	0%	0%	-	-	0%	0%
CNA/CNT - Restorative	-	-	22%	0%	67%	29%	40%	100%
CNA/CNT - Transportation	-	-	0%	0%	-	-	-	-
CNA/CNT - Unit Clerk	-	-	67%	0%	0%	0%	40%	50%

	Clarksville		Humboldt		Knoxville		Murfreesboro	
Job Title	2016	2017	2016	2017	2016	2017	2016	2017
Dietary Aide	-	25%	10%	113%	69%	67%	60%	57%
Dietary Cook	133%	160%	22%	0%	20%	22%	40%	34%
Dietary Manager	-	-	0%	0%	-	-	-	-
Environmental Supervisor	67%	0%	0%	0%	0%	0%	0%	67%
Executive Assistant	-	-	-	-	-	-	200%	-
Floor Tech	-	100%	13%	25%	33%	29%	29%	36%
Housekeeper	0%	14%	0%	10%	17%	8%	10%	94%
Human Resources Director	-	-	-	-	0%	0%	-	-
Human Resource Generalist	0%	100%	-	-	-	-	0%	0%
Human Resources Manager	-	-	0%	0%	-	-	-	-
Kitchen Dietary Manager	0%	0%	200%	100%	0%	0%	0%	100%
Laundry Aide	0%	0%	40%	15%	22%	0%	14%	83%
LPN	0%	131%	16%	54%	38%	56%	61%	24%
LPN - MDS	0%	0%	0%	0%	0%	0%	0%	29%
LPN - Pharmacy Nurse	-	-	0%	0%	-	-	0%	0%
LPN - Restorative	-	-	0%	0%	-	-	0%	0%
LPN - Treatment Nurse	-	-	-	-	67%	67%	-	-
Maintenance Director	0%	0%	0%	0%	0%	0%	200%	0%
Maintenance Tech	0%	100%	0%	0%	50%	40%	40%	50%
Medical Records Manager	-	0%	0%	0%	0%	0%	100%	0%
Patient Account Representative	0%	0%	0%	0%	0%	0%	0%	0%

	Clarksville		Humboldt		Knoxville		Murfreesboro	
Job Title	2016	2017	2016	2017	2016	2017	2016	2017
Receptionist	0%	0%	0%	0%	0%	0%	0%	0%
RN - Case Manager	-	-	0%	50%	-	0%	0%	200%
RN - Director of Nursing	0%	133%	0%	0%	0%	0%	0%	0%
RN - MDS	-	-	67%	0%	0%	0%	-	-
RN - MDS Coordinator	-	-	0%	0%	0%	0%	0%	100%
RN - Pharmacy Nurse	-	-	-	-	67%	0%	-	-
RN - Quality Assurance	-	-	0%	0%	0%	0%	-	200%
RN - Restorative	-	0%	-	-	0%	100%	-	-
RN - Staff Development	0%	200%	0%	0%	0%	0%	0%	67%
RN - Supervisor	80%	175%	57%	60%	40%	50%	100%	13%
RN - Treatment Nurse	-	-	-	-	67%	67%	-	-
RN - Unit Manager	0%	100%	0%	0%	0%	0%	0%	0%
Social Services Assistant	-	0%	33%	0%	0%	0%	33%	0%
Social Services Director	0%	0%	0%	0%	0%	0%	0%	0%
Staffing Coordinator	-	0%	0%	0%	0%	0%	0%	0%
Unit Clerk	-	-	0%	0%	-	-	-	-
Van Driver	-	200%	0%	0%	0%	0%	0%	0%

*Chart does not include positions at the Executive Office in Murfreesboro. It includes positions by home since staff at the homes are the ones more directly responsible for the residents' well-being.
**Data on chart is unaudited and was obtained from reports produced from the homes' Automatic Data Processing (ADP) software. Recalculations of percentages were performed to ensure accuracy.
*** Note that the "-"mark signifies that the home in question did not employ anyone with that job title during the year specified.

RESIDENT ADMISSIONS

Admissions Eligibility

The four veterans' homes were built to provide eligible veterans and their spouses and Gold Star Parents[17] a safe, home-like environment where they can receive a sufficient level of care based on their individual needs. On August 27, 2013, the Tennessee State Veterans' Homes Board approved the "Eligibility for Admissions" policy, which extends eligibility to "[v]eterans who are entitled to medical treatment and/or other benefits from the United States Department of Veterans Affairs (USDVA), and who has met at least one" of five additional requirements listed. Federal and state law only permit the homes to have 25 percent of their beds at any one time occupied by residents who are not veterans.

To assess eligibility for potential residents, admissions staff review documentation such as a DD-214 (Certificate of Release or Discharge from Active Duty) or marriage records. Upon determining eligibility, staff will also analyze how the potential resident will pay for his or her residence in the home. Payor sources may include the VA, Medicare, Medicaid, private insurance, or private pay.[18] The VA does not cover the complete costs unless the potential resident is a veteran with 70% or greater service-connected disability. Potential residents will be denied admission if they cannot cover the costs of living in the home with a combination of one or more payor sources.

After verifying payor sources, admissions staff must ensure that the home can meet the potential resident's individualized needs. Admissions staff accomplish this task by using a Pre-Admissions Screening and Resident Review (PASRR) form, which is a psychiatric evaluation form used to document any mental illnesses an individual may have. Staff review the potential resident's medical history to ensure they can meet the potential resident's medical needs in addition to their psychiatric needs. If the homes cannot meet the potential resident's needs, staff will deny the admission.

Wait Lists

Due to the number of eligible veterans within the state, each of the homes regularly stays close to full capacity. A 1990 court case, *Linton v. Commissioner*, resulted in a federal court ruling mandating that Medicaid-participating facilities admit patients on a first-come, first-served basis to prevent admission order preference based on payor source. The *Rules of Tennessee Department of Finance and Administration, Bureau of TennCare* establish guidelines for implementing wait lists for long-term care facilities, which the veterans' homes are obligated to follow. According to the rules, the wait lists must contain certain information.

[17] According to https://www.army.mil/goldstar/, Gold Star Parents have had a son or daughter killed in action.
[18] Private pay is where the potential resident or someone in his or her family pays the costs.

Additionally, TennCare rules state that wait lists should be updated and revised at least once each quarter to remove the names of previous applicants who are no longer interested in admission to the nursing facility.

The homes have developed an internal policy based on the requirements established in the TennCare rules. The size of the wait lists varies among the four Tennessee State Veterans' Homes (see **Table 18**).

Table 18
Total Number of Veterans on Wait Lists as of March 29, 2018

Murfreesboro	Clarksville	Knoxville	Humboldt	Total
181	256	573	31	**1,041**

We noted the wait lists are not necessarily an accurate reflection of the order of when any potential resident will be admitted to one of the homes. Along with the requirements described previously, the rules include instances when a potential resident may be admitted according to circumstances beyond first-come, first-served, regardless of their position on a wait list. The most common example of this type of admission is going directly to a home from the hospital due to medical need. Also, because nursing facilities place only residents of the same gender together in each room, admission order may depend on whether the potential resident is male or female. Admission preference may further be given in cases requiring intervention by the Department of Human Services' Adult Protective Services and in limited instances of resident transfer from another facility.

Audit Results

1. **Audit Objective:** Did management admit only residents who were eligible under the requirements established in the *Code of Federal Regulations*, *Tennessee Code Annotated*, and internal policy?

   Conclusion: Based on audit work performed, management followed applicable guidelines when admitting new residents to the homes; however, we determined state guidance does not clearly define residency requirements (see Observation 3).

2. **Audit Objective:** Did management only deny applications for potential residents who did not qualify for admission into the homes?

   Conclusion: We found that management's denials were reasonable.

3. **Audit Objective:** Did management follow TennCare rules and its own internal policy for admitting residents off the wait list?

   Conclusion: While management appropriately admitted residents to the homes, we determined that they did not always ensure that staff included all required information in the wait lists (see **Finding 11**).

Finding 11: Management did not ensure that the wait list at each of the four veterans' homes contained required information and that the lists were updated in accordance with established policies and procedures

Based on our analysis,[19] management did not always ensure the wait lists for each facility contained necessary information or were updated as required by both state and internal policies and procedures. **Table 19** indicates the specific wait list requirements where we noted the admissions staff in each home did not complete all required wait list information for one or more homes. For each field required, if management and staff completed the field for at least 95% of applicants added to the wait list during the audit period, we considered the field complete.

Table 19
Wait List Requirements Not Completed

	TennCare Rule Requirements	Murfreesboro	Clarksville	Knoxville	Humboldt
	Number of Applicants Added to Wait List During Audit Period	132	248	514	13
1	Name of applicant	Complete	Complete	Complete	Complete
2	Name of contact person/designated representative	Complete	Complete	Complete	Complete
3	Address of the applicant, contact person, or designated representative	Complete	Complete	Complete	Complete
4	Telephone number of applicant, contact person, or designated representative	Complete	Complete	Complete	Complete
5	Name of person/ agency referring the applicant to the nursing facility	**Not Complete 31 of 132 23%**	**Not Complete 25 of 248 10%**	Complete	Complete
6	Sex and race of applicant	Complete	Complete	Complete	Complete
7a	Date of the request for admission	Complete	Complete	Complete	Complete

[19] We obtained the wait lists and identified applicants who were added to the wait lists during the period January 1, 2015, through March 29, 2018, which was the day we received the wait lists from management. We analyzed the wait lists from each of the four veterans' homes to ensure that admissions staff included all required information for applicants added during our audit period and, as required, regularly contacted all applicants on the wait lists to verify they wanted to remain on the lists.

7b	Time of the request for admission	**Not Complete** **23 of 132** **17%**	Complete	Complete	Complete
8	Reasons for refusal/ non-acceptance other- action-taken	Complete	**Not Complete** **72 of 248** **29%**	**Not Complete** **309 of 514** **60%**	**Not Complete** **12 of 13** **92%**
9	Name and title of the home's employee taking the application for admission	**Not Complete** **22 of 132** **17%**	Complete	Complete	Complete
10	A notation stating whether the applicant is anticipated to be Medicaid eligible at the time of admission or within one year of admission.	**Not Complete** **115 of 132** **87%**	**Not Complete** **36 of 248** **15%**	**Not Complete** **514 of 514** **100%**	Complete

In addition, our testwork revealed that the Admissions Directors at the Clarksville, Knoxville, and Humboldt homes did not always document whether they contacted each person on the wait list quarterly to verify whether they wanted to remain on the wait list.

- *Clarksville* – We noted at least one contact attempt for each applicant on the wait list, but staff did not document each quarterly contact attempt for every applicant.
- *Knoxville* – While the wait list included fields to document contact attempts, staff did not document at least one contact attempt for 448 of 573 total applicants on the wait list (78%).
- *Humboldt* – The wait list included a field for notes including contact dates and times; however, staff did not document contact attempts for any of the applicants on the wait list.

- *Murfreesboro* – We did not note any issues with documentation of quarterly contacts.

We noted that each home has a wait list template with the appropriate fields that needed to be completed and that the employees are trained in the proper procedures; yet, staff did not follow the template. By not completing or updating the wait lists as required, management increases the risk that future resident admissions could be delayed, causing empty beds within homes, fewer services to deserving veterans, and less revenue to provide much-needed services for our veterans.

Recommendation

The Executive Director should ensure that admissions staff at each facility understand their responsibilities to complete and update the wait lists in accordance with state rules and the homes' wait list policy. Management should also consider revising policies to establish necessary controls to ensure staff complete the following for each applicant:

- documenting all necessary information about the applicant in the fields provided in the wait list template;
- contacting all applicants on the wait list quarterly to verify applicants want to remain on the wait list; and
- documenting all contact attempts and responses for each applicant on the wait list.

Management's Comment

We concur. Management provided training to key staff responsible for the wait list information on September 18, 2018. Management reeducated staff on the state rules for the wait list and the importance of providing all information. The standard wait list will be developed and provided to all homes by November 1, 2018. Management will monitor the homes' compliance with the new wait list format.

Observation 3 – Veterans' homes board policy lacks specific requirements for establishing Tennessee residency

The Tennessee State Veterans' Homes Board's "Eligibility For Admissions" policy states the following:

Figure 22
Excerpt From Board's Admissions Policy

Veterans who are entitled to Medical treatment and/or other benefits from the USDVA, and who also meet at least one of the additional requirements listed below are eligible for admission to the Tennessee State Veterans Homes –

A. Resident of Tennessee at time of admission

B. Born in Tennessee

C. Entered the U.S. Armed Forces in Tennessee

D. Tennessee address is official Home of Record on Veteran's Military Record

E. Has an immediate family member (Parent, Spouse, Sibling, or Child) or Legal Guardian who would serve as primary caregiver, who is a resident of Tennessee

Spouse, Widow or Gold Star Parent may be eligible for admission on a space available basis.

The policy does not, however, contain specific provisions for determining residency.

We noted in our admissions testwork[20] that the Clarksville facility admitted a veteran on April 17, 2017. Based on our review of his admissions package, the veteran had previously lived in Kentucky and had no connection with Tennessee other than an approximate two-month stay in the Veterans Administration's (VA) Hospital in Murfreesboro immediately prior to admission to the Clarksville facility. According to the Director of Clinical Services, the veteran was admitted because a pre-admission screening for TennCare had listed the VA hospital in Murfreesboro as the veteran's address.

State law currently does not include specific statutes to determine residency for admissions into state veterans' homes but does list acceptable ways to establish a Tennessee residency for TennCare. According to Section 71-5-120 (b)(1), *Tennessee Code Annotated*, an individual can prove residency in Tennessee upon providing

- a Tennessee mortgage or rent statement,
- utility bill from a utility in Tennessee,
- a Tennessee's driver's license,
- employment records in Tennessee,
- proof of a child in school in Tennessee,
- evidence that the individual is receiving public assistance in Tennessee, or
- proof that the individual is registered to vote in Tennessee

Without specific eligibility requirements for admission to a veterans' home, it is difficult to determine if management is adhering to legislative intent. Whether the legislature intended there to be more of a connection to the state than an extended stay at a Tennessee VA hospital is unknown. In researching other general requirements for residency, we noted that several federal requirements[21] extend residency eligibility to include those who are just intending on living or working in the state. In the case of the Clarksville facility admission, however, the veteran's intent could not be determined from the available documentation. Furthermore, additional federal guidelines[22] go as far as stating that individuals visiting the area for a transitory purpose, such as to obtain medical care, do not have the "intent to reside" and do not meet the residency requirement for some programs.

[20] We tested the 1,693 residents admitted to one of the Tennessee State Veterans' Homes during the period January 1, 2015, through March 29, 2018. We selected 15 admissions from each of the 4 homes (Murfreesboro – 440 admissions, Humboldt – 491, Knoxville – 462, and Clarksville – 300), for a total of 60 tested.

[21] Examples are Title 42, *Code of Federal Regulations* (CFR), Section 435.403 and 45 CFR 155.305.

[22] Centers for Medicare and Medicaid Services' Center for Consumer Information and Insurance Oversight memo dated January 19, 2016.

We recommend that the board clarify its policy on admissions to include specific requirements for establishing Tennessee residency.

Matter for Legislative Consideration

The General Assembly may wish to consider defining the eligibility requirements to establish Tennessee residency for admissions into our state veterans' homes, including but not limited to whether an individual can establish residency through a long stay in a Tennessee hospital.

GENERAL ADMINISTRATION

Comprehensive Emergency Management Plan

The Centers for Medicare and Medicaid Services (CMS) require nursing homes to develop disaster recovery plans that encompass specific steps to take in the event of an emergency. In our 2009, 2012, and 2014 sunset performance audits, we found that the veterans' homes did not include all of CMS's requirements in their disaster recovery plans.

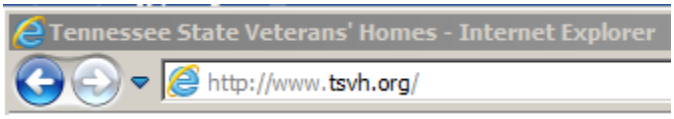
Information Systems and Website

Since the homes maintain files of resident medical information, it is important that management has internal controls in place to comply with privacy regulations in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). One way the homes achieve HIPAA compliance is through information system controls. The homes use three main systems: *PointClickCare* electronically stores resident records and information, *Accufund* manages their fiscal operations, and *Automatic Data Processing (ADP)* handles payroll functions.

In addition to HIPAA, management must ensure adherence to state information security policies and industry best practices for each system.

The homes also operate a website to communicate to the public operational information about their operations, such as

- home locations;
- admissions requirements;
- activity calendars;
- services and therapies offered; and
- employment opportunities.



Risk Assessment

Section 9-18-104, *Tennessee Code Annotated*, requires the head of each state agency and higher education institution to assess the risks and systems of internal control in accordance with the guidelines established by the Department of Finance and Administration, in consultation with the Comptroller of the Treasury. Section 9-18-102 lists the objectives of risk assessments (see **Figure 23**).

Figure 23
Risk Assessment Objectives From Section 9-18-102, *Tennessee Code Annotated*

(a) Each agency of state government and institution of higher education along with each county, municipal, and metropolitan government shall establish and maintain internal controls, which shall provide reasonable assurance that:

(1) Obligations and costs are in compliance with applicable law;

(2) Funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and

(3) Revenues and expenditures are properly recorded and accounted for to permit the preparation of accurate and reliable financial and statistical reports and to maintain accountability over the assets.

(b) To document compliance with the requirements set forth in subsection (a), each agency of state government and institution of higher education shall annually perform a management assessment of risk. The internal controls discussed in subsection (a) should be incorporated into this assessment. The objectives of the annual risk assessment are to provide reasonable assurance of the following:

(1) Accountability for meeting program objectives;

(2) Promoting operational efficiency and effectiveness;

(3) Improving reliability of financial statements;

(4) Strengthening compliance with laws, regulations, rules, and contracts and grant agreements; and

(5) Reducing the risk of financial or other asset losses due to fraud, waste and abuse.

Section 9-18-104 also requires the head of each state agency and higher education institution to submit an annual Financial Integrity Act report by December 31 of each calendar year to both the Commissioner of the Department of Finance and Administration and the Comptroller of the Treasury. In this report, agency or institution management 1) acknowledges responsibility for establishing, implementing, and maintaining an adequate system of internal control and 2) states whether an assessment of risk performed by the agency or institution provides reasonable assurance of compliance with the objectives of the assessment as specified in statute. In the event that the agency's or institution's assessment does not provide reasonable assurance of compliance with the objectives of the assessment as stated in statute, the report is to include a corrective action plan.

Possible Unlawful Conduct

One responsibility of the Comptroller's Office involves assisting agency management when they find or suspect the occurrence of fraud, waste, abuse, or other possible unlawful conduct in their agencies. *Tennessee Code Annotated* requires agencies, including the Tennessee State Veterans' Homes Board, to report such claims to us in a timely manner so we can then make the appropriate investigative resources available.

1. **Audit Objective:** Did management correct the 2009, 2012, and 2014 Comprehensive Emergency Management Plan finding?

   Conclusion: While the homes did not completely correct the prior finding, they have achieved federal compliance due to the generalization of regulations (see Observation 4).

2. **Audit Objective:** Did management ensure adherence to state information security policies and industry best practices?

   Conclusion: Management adhered to state information security policies and industry best practices.

3. **Audit Objective:** Did management have controls in place to ensure the protection of resident information in accordance with HIPAA?

   Conclusion: Management implemented adequate controls over resident information.

4. **Audit Objective:** Did management maintain a website with updated home information?

   Conclusion: In August 2017, management contracted with an outside company to recreate the website, which when completed will enable management to more easily present accurate and complete information.

5. **Audit Objective:** Did management properly perform annual risk assessments?

   Conclusion: Management did properly perform the risk assessments.

6. **Audit Objective:** Did management report instances of actual or possible unlawful conduct to our office as required by state statute?

   Conclusion: Management did not always make reports to our office within the timeframe specified by state statute (see **Finding 12**).

Finding 12 – Management did not notify the Comptroller's Office of possible unlawful conduct in a reasonable amount of time, as required by state statute

Our audit work revealed that during the period January 1, 2015, through June 1, 2018, Tennessee State Veterans' Homes Board management did not notify our office of at least three instances of possible unlawful conduct regarding administrative matters in a reasonable amount of time.

Section 8-4-503, *Tennessee Code Annotated*, states,

> A public official with knowledge based upon available information that reasonably causes the public official to believe that unlawful conduct has

> occurred shall report the information in a reasonable amount of time to the office of the comptroller of the treasury.

Section 8-4-502, *Tennessee Code Annotated*, defines a reasonable amount of time as not more than five working days.

Additionally, according to Section 8-19-501(a),

> Any official of any agency of the state having knowledge that a theft, forgery, credit card fraud, or any other act of unlawful or unauthorized taking, or abuse of, public money, property, or services, or other shortages of public funds has occurred shall report the information immediately to the office of the comptroller of the treasury.

It is vital that home management notify the Comptroller's Office of possible unlawful conduct as quickly as possible, as required by law, so that we can assist management with steps to address any malfeasance noted. By not giving the Comptroller's Office the opportunity to involve trained investigators, management can potentially hinder further investigation of matters and may endanger the prosecution of illegal acts. Furthermore, management increases the risks for additional misconduct to occur if such matters are not appropriately reviewed.

Recommendation

The board should ensure that executive management takes the necessary actions to

- educate all employees in the homes about their responsibilities to report suspected unlawful conduct to the Comptroller's Office;
- ensure that all suspected unlawful conduct is reported timely to our office; and
- designate an employee, such as the Financial Compliance Officer, as the individual primarily responsible for such reporting of unlawful conduct.

Management's Comment

We concur. Management was not aware of the TCA five-day requirement for reporting suspected unlawful conduct to the Comptroller's Office. Management did contact the Tennessee Attorney General's Office for guidance on two of the three suspected unlawful conduct. The Tennessee Attorney General's Office approved management obtaining outside counsel for guidance. The Comptroller's Office was notified once that decision was made by the Tennessee Attorney General's Office. Management will provide education on timely reporting of suspected unlawful conduct with key staff by December 1, 2018.

Observation 4 – While the homes did not completely correct the prior emergency preparedness finding, they have achieved federal compliance due to the generalization of regulations

General Background

Federal regulations require that Medicare- and Medicaid-certified nursing homes have written plans and provide employees with training to prepare for emergencies such as fires, severe weather, floods, earthquakes, and missing residents. The U.S. Department of Health and Human Services (DHHS) conducted a study in 2012 and found the federal regulations to be inadequate in real-life tests of nursing homes in disaster situations. From 2007 to 2010, several disasters substantially affected at least 210 nursing homes in 7 states, forcing residents to evacuate or shelter in place in response to floods, hurricanes, and wildfires. In Tennessee, the May 2010 flooding of the Mississippi and Cumberland rivers forced the full evacuation of two nursing homes, the partial evacuation of another, and the residents of four other nursing homes to shelter in place.

As a result of its study, DHHS recommended specific requirements for emergency plans including the use of checklists from the Centers for Medicare and Medicaid Services (CMS).

Results From Prior Audits

During our September 2012 audit, we reported that, as found in our March 2009 audit, the three separate veterans' home[23] disaster plans still needed improvements to include important industry-recommended provisions. Specifically, although the homes were technically in compliance with regulations as assessed by the Tennessee Board for Licensing Health Care Facilities and the U.S. Department of Veterans Affairs, their disaster plans did not address many of the recommended CMS provisions for emergency preparedness and response. We noted in our November 2014 follow-up report that the homes created a new, significantly improved combined emergency management plan that included most of the recommendations from the CMS checklist; however, the plan still did not meet or adequately meet several tasks on the checklist.

Results of Current Audit Work

During the current audit, we held discussions with management regarding the homes' emergency management plan and reviewed documentation to verify revisions to the plan. Since the prior audit, management had

- reached agreements with various local long-term care facilities to house residents short-term in the case of an emergency evacuation and incorporated those written agreements into the emergency management plan, and

[23] The Murfreesboro, Humboldt, and Knoxville homes existed during the prior audits; the Clarksville home did not become operational until 2015.

- added possible sources of transportation and supplies to the plan.

We determined that management did not implement the following prior audit recommendations to

1. acquire contracts with vendors for supplies and transportation;
2. develop procedures concerning the death or illness of a resident during an evacuation;
3. require a designee to maintain the safety of key information attached to each resident;
4. detail how residents will be assisted with packing their belongings or how their possessions will be protected after an evacuation; and
5. send the emergency management plan to the state's long-term ombudsman.

When we reviewed the *Federal Register* dated September 2016, though, we discovered that the CMS regulations—Title 42, *Code of Federal Regulations*, Part 483.73—had been updated and generalized. Therefore, the CMS checklist no longer contained the five items that management declined to implement for various reasons, one of which was that staff purportedly already know what to do in an emergency.

FEDERAL REGISTER
The Daily Journal of the United States Government

Veterans' homes management may nonetheless wish to continue to improve the quality of its emergency management plan by incorporating the remaining elements in the previous CMS checklist.

BOARD OF DIRECTORS

As noted in the background section, Section 58-7-102, *Tennessee Code Annotated*, requires a 13-member board representing various areas of expertise and regions of the state. The board maintains two committees that regularly meet: executive and audit. The board's bylaws require that the board meet not less than three times per year, with seven voting members constituting a quorum. These meetings are subject to the state's open meetings requirements in Sections 8-44-102 and 8-44-104, *Tennessee Code Annotated*. Section 58-7-106 requires board members to make known any conflict of interest involving a matter before the board, and to be prohibited from voting on the matter.

Board

In accordance with Section 58-7-103, *Tennessee Code Annotated*, the Tennessee State Veterans' Homes Board's prescribed powers and duties include the authority to

- determine the location of the veterans' homes, giving preference to public land;
- acquire, hold, sell, assign, lease, rent, encumber, mortgage, or otherwise dispose of any real or personal property;

- incur debts, borrow money, and issue debt instruments;
- procure insurance against any loss in connection with its property and other assets;
- have employees designated by the board solicit and receive bequests and donations;

- seek advice or assistance from the United Tennessee Veterans' Association, the Commissioner of the Department of Finance and Administration, the Comptroller of the Treasury, the state Treasurer, and other state agencies;
- adopt written policies and procedures to govern its internal operations; and
- do other acts as necessary "to exercise the powers granted or reasonably implied in this section."

Executive Committee

The Executive Committee is responsible for the oversight of the day-to-day management and operation of the homes. In accordance with Section 58-7-104, *Tennessee Code Annotated,* the prescribed powers and duties of the Executive Committee include the authority to

- employ an executive director, employ other employees, and incur any necessary expenses;
- establish policies regarding resident care rates;
- make and execute contracts;
- establish the compensation of the executive director and perform an annual review of the executive director; and
- file a quarterly report with the Fiscal Review Committee concerning the operations of each state veterans' home.

Audit Committee

In accordance with Section 4-35-105, *Tennessee Code Annotated*, the board maintains an Audit Committee. Per state law, the Audit Committee's responsibilities include

- overseeing the financial reporting and related disclosures;
- evaluating management's assessment of internal controls;
- formally reiterating to the board, management, and staff their responsibility for preventing, detecting, and reporting fraud, waste, and abuse;

- serving as a facilitator of any audits or investigations of the board;

- informing the Comptroller of the Treasury of the results of assessment and controls to reduce the risk of fraud; and
- promptly notifying the Comptroller of the Treasury of any indications of fraud.

Audit Results

1. **Audit Objective:** Did the board meet statutory requirements for member composition?

   Conclusion: Based on our review, the board met these statutory requirements.

2. **Audit Objective:** Did the board have policies and procedures in place to identify and prevent conflicts of interest of board members, and did board members annually sign the conflict-of-interest acknowledgement statement?

   Conclusion: We found that the policies and procedures the board had in place needed improvement. Additionally, some board members did not annually sign the conflict-of-interest acknowledgement statement (see Observation 5).

3. **Audit Objective:** In meetings, did the board achieve the quorum standard promulgated by its bylaws?

   Conclusion: Our testwork disclosed that the board had quorums at its meetings.

4. **Audit Objective:** Did board members consistently attend meetings?

   Conclusion: We determined that although most of the board members consistently attended meetings, a few were frequently absent (see Observation 6).

5. **Audit Objective:** Did the board correct the observation reported in the September 2012 sunset performance audit report by complying with open meetings requirements established in *Tennessee Code Annotated*, including:

   - providing adequate public notice of board and committee meetings;
   - listing the Executive Director's annual evaluation on the Executive Committee agenda; and
   - holding open meetings to discuss the Executive Director's annual evaluation and salary?

   Conclusion: Notices of three public board and committee meetings were not posted to the homes' website, and management could not provide the exact dates when public notices had been posted to the website. Furthermore, while the Executive Director's annual evaluation was posted to the Executive Committee agendas, there were violations of open meeting requirements concerning the Executive Director's annual review by the Executive Committee (see Observation 6).

6. **Audit Objective:** Did the board engage in strategic planning to anticipate the needs of the veteran community?

   Conclusion: The board engaged in strategic planning to anticipate the needs of the veteran community. As of the end of our fieldwork, the board is planning to build three additional homes (see Observation 7).

Observation 5 – The board did not designate space on its Conflict-of-Interest Policy acknowledgment statement for the disclosure of actual or potential conflicts and did not annually obtain signed statements from all members

An essential method of maintaining public trust in, and ensuring the proper performance of, government involves disclosing potential conflicts of interest. During our testwork, we found that the Tennessee State Veterans' Homes Board

- did not provide a space on its Conflict-of-Interest Policy acknowledgment statement for the disclosure of actual or potential conflicts; and
- did not annually obtain signed statements from all members.

Conflict-of-Interest Disclosure Requirements

Both the board's own policies and state law codify conflict-of-interest disclosure requirements.

Board's Policy

According to the board's Conflict-of-Interest Policy,

> Tennessee State Veterans' Homes Board [TSVHB] members have a primary obligation to serve the purposes to which the board is dedicated. As part of this obligation, each Board member has a duty to conduct his or her Board duties and the affairs of the Board in a manner that promotes the best interest of the organization. A potential conflict of interest exists when the Board member's personal interests or activities influence or appear to influence the member's ability to promote objectively the best interests of the TSVHB.

The policy additionally states, "Each member shall annually sign a statement which affirms that such person has received a copy of the Conflict of Interest Policy, has read and understands the Conflict of Interest Policy, and has agreed to comply with the Conflict of Interest Policy." The board's bylaws define the fiscal year as July 1 through June 30.

State Law

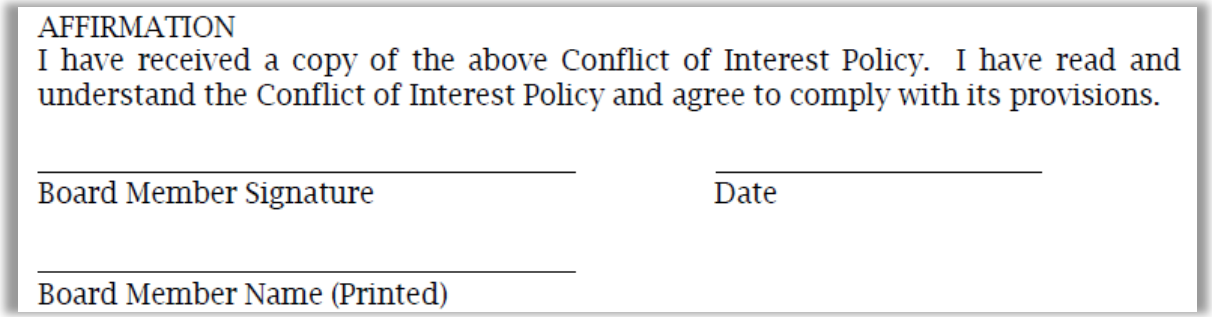
The section of state law governing the veterans' homes also addresses conflicts of interest. Specifically, Section 58-7-106, *Tennessee Code Annotated*, establishes the following: "If any matter before the board involves a project, transaction, or relationship in which a member or the member's associated institution, business or board has a direct or a conflicting interest, the member shall make known to the board that interest and shall be prohibited from participating in discussions and voting on that matter."

Testwork Results

No Designated Space for Disclosures

Our examination revealed that the board appended an acknowledgment statement to its Conflict-of-Interest Policy that lacked a space for members to disclose actual or potential conflicts. See **Figure 24**.

Figure 24
Board's Full Conflict-of-Interest Policy Acknowledgment Statement


AFFIRMATION
I have received a copy of the above Conflict of Interest Policy. I have read and understand the Conflict of Interest Policy and agree to comply with its provisions.

_____ _____
Board Member Signature Date

_____
Board Member Name (Printed)

Based on discussion with the Finance Director, who serves as a liaison to the board and maintains the acknowledgment statements, this space had not been added because the Conflict-of-Interest Policy details the steps a board member should take if a known conflict arises during meetings. The policy stipulates that in such a case, the board member should recuse himself or herself from the conversation, leave the room, and abstain from voting on issues involving the conflict.

When we inspected the board minutes for the period January 22, 2015, through March 15, 2018, we noted that no board members had communicated that they had a conflict. We also were not alerted to or are aware of any unreported conflicts.

The Finance Director told us that management is open and willing to update the Conflict-of-Interest Policy acknowledgment statement so that board members will have a space to disclose actual or potential conflicts. We believe this addition will further enhance the transparency of board business.

Acknowledgment Statements Not Obtained

Our testwork disclosed the following conditions:

- Period of July 1, 2015, through June 30, 2016 – Two of 13 board members (15%) did not sign and return their Conflict-of-Interest Policy acknowledgment statement prior to performing board-related duties. The Finance Director said that although management made repeated attempts to get the two board members to sign, including mailing acknowledgment statements to their home addresses, the board members were preoccupied with other obligations.
- Period of July 1, 2017, through June 30, 2018 – Upon talking with the Finance Director at the beginning of March 2018, we learned that none of the 13 board members (0%) had completed the acknowledgment statements. The Finance Director explained that the Executive Assistant who typically distributed the Conflict-of-Interest Policy and accompanying statements during the July board meeting was on extended leave and that management did not provide an alternative solution for the timely signing of the statements. By March 28, 2018, the Finance Director had collected signed fiscal year 2018 acknowledgment statements from all 13 board members.

In the absence of a completed acknowledgment statement, no formal attestation exists that the board members understand the Conflict-of-Interest Policy and agree to comply with it. Therefore, the board chair, in conjunction with the Finance Director, should ensure that each board member annually signs and returns an acknowledgment statement.

Observation 6 - The board needs to improve some aspects of its meetings

The full Tennessee State Veterans' Homes Board normally holds meetings every two months. The board consists of two regular committees—the Audit Committee and the Executive Committee—that normally meet prior to the main board meeting. In our 2012 sunset audit, we included an observation that the board needs to improve its practices for making adequate public notice of its meetings and for giving notice and holding open discussion of the Executive Director's annual review.

During the current audit, we examined each board and committee meeting that occurred during our audit period of January 1, 2015, through June 30, 2018:

- **fiscal year 2015 within our audit period (January 2015 through June 2015)**
  - board – 4 meetings
  - Audit Committee – 3 meetings
  - Executive Committee – 4 meetings

- **fiscal year 2016 (July 2015 through June 2016)**
  - board – 6 meetings
  - Audit Committee – 6 meetings
  - Executive Committee – 5 meetings
- **fiscal year 2017 (July 2016 through June 2017)**
  - board – 6 meetings
  - Audit Committee – 4 meetings
  - Executive Committee – 6 meetings
- **fiscal year 2018 (July 2017 through June 2018)**
  - board – 5 meetings
  - Audit Committee – 3 meetings
  - Executive Committee – 5 meetings.

We identified several areas for improvement regarding the board and committee meetings. Namely, we noted that the board's website did not include public notices for all meetings; there were violations of open meeting requirements; and some board members were frequently absent.

Meetings Not Posted to Website

We determined that notice was not posted to the board's website for 1 of 6 board meetings in fiscal year 2016 (17%), 1 of 6 board meetings in fiscal year 2017 (17%), and 1 of 6 Executive Committee meetings in fiscal year 2017 (17%). Additionally, we learned that management could not provide us with documentation of the exact dates when public notices had been posted to the website.

Section 8-44-103(a), *Tennessee Code Annotated*, states, "Any such governmental body which holds a meeting previously scheduled by statute, ordinance, or resolution shall give adequate public notice of such meeting." The Finance Director stated that notices for all board meetings are posted at each home and at Legislative Plaza in downtown Nashville, Tennessee. However, this action does not fully satisfy public notice requirements when considering today's technological capabilities, including the fact that the board maintains a website where notice is normally posted in order to make it widely assessible to the public.

According to the Director of Information Technology, the board used a free website management software, which often experienced technological issues that apparently affected the posting of notices and the availability of an audit trail for the posting dates. At the time of our audit, management was in the process of having a new website created by a contractor.

Violations of Open Meetings Act

Based on review of meeting minutes, during the March 2017 Executive Committee meeting, the then-chair asked those attendees not on the committee to exit the room, during which time the homes' Executive Director's annual performance evaluation and potential salary increase were discussed. Likewise, the new Executive Committee chair asked guests to leave the room during the March 2018 committee meeting discussion of the Executive Director's annual performance evaluation and potential raise in salary.

Section 8-44-102(a), *Tennessee Code Annotated*, establishes, "All meetings of any governing body are declared to be public meetings open to the public at all times, except as provided by the Constitution of Tennessee." Section 8-44-104 adds that

> (a) The minutes of a meeting of any such governmental body shall be promptly and fully recorded, shall be open to public inspection, and shall include, but not be limited to, a record of persons present, all motions, proposals and resolutions offered, the results of any votes taken, and a record of individual votes in the event of roll call.
>
> (b) All votes of any such governmental body shall be by public vote or public ballot or public roll call. No secret votes, or secret ballots, or secret roll calls shall be allowed. As used in this chapter, "public vote" means a vote in which the "aye" faction vocally expresses its will in unison and in which the "nay" faction, subsequently, vocally expresses its will in unison.

Our discussions with the Finance Director and the Director of Risk Management disclosed that board members have been reminded of the open meetings requirements but mistakenly asked some in attendance to leave. Although the board may prefer privacy for themselves and the Executive Director when discussing the latter's performance evaluation, when the public is not allowed to attend board or committee meetings, they lose the opportunity to remain informed of pertinent information and changes within the Tennessee State Veterans' Homes.

Members Frequently Absent

We examined the minutes of each of the overall board meetings that occurred during our audit period, as listed above. We reviewed meeting attendance to determine if a quorum was achieved at each meeting and to determine if any board member was frequently absent. Specifically, we tested absences and noted any board member who was absent for more than 50% of the board meetings during any of the fiscal years in our audit period.

The board's bylaws state that a quorum requires 7 of the 13 board members to be present. Although we determined that all the board meetings achieved a quorum, we did identify some board members who were absent for over 50% of the meetings:

- **fiscal year 2015 within our audit period (January 2015 through June 2015)**
    - Member A – absent 3 of 4 meetings (75%)
- **fiscal year 2016 (July 2015 through June 2016)**
    - Member A – absent 6 of 6 meetings (100%)
    - Member B – absent 3 of 4 meetings (75%)[24]
- **fiscal year 2017 (July 2016 through June 2017)**
    - Member C – absent 4 of 6 meetings (67%)
- **fiscal year 2018 (July 2017 through June 2018)**
    - Member D – absent 3 of 5 meetings (60%)

According to the Finance Director, the board members had various reasons for absences: job obligations prevented Member A and Member B from attending all of the meetings; Member C had health issues; and Member D had various reasons including both job obligations and family member health issues. Member A and Member B are no longer members of the board.

While it is reasonable that members may have to miss meetings from time to time, if board members are frequently absent, the board cannot ensure that each meeting will have a quorum and that all 13 members are participating and representing their field of expertise or geographic region of the state, as prescribed by *Tennessee Code Annotated*.

Recommendation

The Director of Information Technology should ensure that all public notices of meetings are posted to the board's website in a timely manner. He should further ensure that an audit trail exists to determine the dates the notices were posted to the website.

The board and committee chairs should adhere to the Open Meetings Act. Moreover, the Executive Director should provide opportunities for additional training to ensure all board members and members of management are aware of the Open Meetings Act and all its requirements.

The chair of the board and the Executive Director should emphasize to all board members the importance of meeting attendance to achieve a physical quorum so that business can be conducted and voting can take place. They should also consider coordinating the removal of consistently absent members.

[24] Member B did not join the board until November 2015; therefore, he was not a member of the board during the first two meetings of the fiscal year.

Observation 7 – The board has recently opened one home and has plans to open three additional homes

Section 58-7-103(c), *Tennessee Code Annotated*, grants authority to the Tennessee State Veterans' Homes Board (the board) to determine the location of veterans' homes. Section 58-7-101(c), *Tennessee Code Annotated*, states that "homes shall be established and operated only if federal veterans' administration funds are available to meet a substantial part of any construction costs incurred in the establishment of such homes." The U.S. Department of Veterans Affairs (VA) provides 65% of the funding needed for the construction of new homes. To supplement that funding, the interested community can raise funds through a mix of state government, local government, and donated resources.

The board works in conjunction with the Department of Veterans' Services, the Department of General Services' State of Tennessee Real Estate Asset Management (STREAM) Division, and the State Building Commission to plan and construct new veterans' homes. The locations of the homes, resident capacity, and the order in which homes are built are determined primarily based on available funding rather than the number of veterans living in a particular region. For example, the Southwest Tennessee area has a higher veteran population than the Southeast Tennessee area;[25] however, since local funding for the home in Southeast Tennessee was raised prior to funding becoming available for the home in Southwest Tennessee, the Southeast Tennessee home will be built first.

We reviewed documents and discussed with board officials plans for existing homes and plans to add new homes for the different regions of the state. See **Table 20**.

Middle Tennessee

In December 2015, the Brigadier General Wendell H. Gilbert Tennessee State Veterans' Home located at 250 Arrowood Drive, Clarksville, TN, started admitting private-pay residents. In order to receive Medicare/Medicaid residents, the home had to receive certification from the Centers for Medicare and Medicaid Services (CMS). CMS conducts a Life of Safety Licensure Survey to certify skilled nursing homes. On October 13, 2015, CMS surveyed the Clarksville home, but the home failed to pass due to construction-related issues such as firestop systems and fire doors. Because of these issues, management was at first unable to accept Medicare/Medicaid residents, leading to operational losses for the home.[26]

The new facility was ultimately dedicated on January 11, 2016; gained CMS certification on May 10, 2016; and received VA recognition in October 2016.

[25] For further information, see the map depicting veteran population by county on page 9.
[26] Our office presents detailed financial data for the homes in financial statement audit reports.

Southeast Tennessee

As of the end of our fieldwork, Cleveland-Bradley County ranked in group 1 on the VA priority list.[27] The current construction plans include building a 108-bed intermediate and skilled care nursing facility on 28.29 acres of donated land. This project is in the design phase. The VA notified the board in April 2018 that requested funding had become available, and the board estimates construction for the home to be completed in 2019.

Figure 25
Future Site of Cleveland-Bradley County Veterans' Home

Southwest Tennessee

A grant application for the construction of a 126-bed intermediate and skilled care nursing facility in Arlington-Shelby County was submitted in April 2018. The property for this project has been purchased and was originally part of the State of Tennessee's Department of Intellectual and Developmental Disabilities. The board estimates construction to begin in 2020 and to be completed in 2021.

[27] The Secretary of the Department of Veterans Affairs compiles a list prioritizing the applications that were received on or before August 15 and that were approved under Title 38, *Code of Federal Regulations*, Section 59.20. Applications are prioritized from highest to lowest in priority groups 1 through 7, with group 1 being the highest priority.

Figure 26
Future Site of Arlington-Shelby County Veterans' Home

Northeast Tennessee

A steering committee has formed to develop a state veterans' home in Sullivan County. A site analysis has been completed on a donated plot of land on Highway 11 East. The design phase is estimated to begin in 2020 with construction completed in 2023.

Figure 27
Future Site of Sullivan County Veterans' Home

Table 20
Future Tennessee State Veterans' Homes

Region	Southeast TN	Southwest TN	Northeast TN
County Location	Bradley	Shelby	Sullivan
Address	1960 Westland Drive Cleveland, TN	11293 Memphis Arlington Road Arlington, TN	Highway 11 East Sullivan County
Accommodations	108-Bed Intermediate and Skilled Care Nursing Facility	126-Bed Intermediate and Skilled Care Nursing Facility	Will be determined during planning phase of project (2020)
Estimated Total Project Cost[28]	$47,729,558	$54,801,061	-
State, Local, and Donations	$17,205,020	$28,900,000	-
Estimated Allowable Federal share (65% of Project Cost)	$26,224,263	$35,620,690	-
Estimated Construction Start Date	Mid 2019	2020	2022

[28] The total project budget is set by the State of Tennessee Real Estate Asset Management Division (STREAM). The budget is an estimated cost for the project and may change throughout the course of construction due to operational changes and the construction schedule; therefore, the amount of local/state matches and the estimated allowable federal share are not going to equal the total project costs.

APPENDICES

APPENDIX 1
Methodology to Achieve Audit Objectives

RESIDENT CARE

Quality of Life

To obtain an understanding of the Quality of Life Standards set forth for residents, we reviewed Title 38, *Code of Federal Regulations*, Section 51.120 (Quality of Care) and Section 51.100 (Quality of Life Standards). We obtained and reviewed agency policies and other relevant documentation to determine how management communicated the standards and incorporated them into the homes' operations.

Moreover, we accessed the Centers for Medicare and Medicaid Services (CMS) website, pulling Quality of Resident Care ratings for each home as of May 2018. We requested from management a history of Quality of Resident Care ratings since January 1, 2015. We also obtained various data on the number of residents who were short-stay versus long-term, as well as the monthly reports the homes use to track the CMS measures.

Assessments

We reviewed internal policies and interviewed key personnel to obtain an understanding of the assessment processes. We also reviewed the CMS *Long-Term Care Facility Resident Assessment Instrument Manuals* for best practices.

For admissions assessments, we selected a random, nonstatistical sample of 60 residents, 15 residents from each of the 4 homes, from a population of 1,693 total residents[29] who entered the homes during the period January 1, 2015, through March 29, 2018.

For the Quarterly/Annual/Significant Change Assessments, we tested a separate random, nonstatistical sample of 35[30] residents from a population of 2,036 residents[31] who resided in the homes during the period January 1, 2015, through March 29, 2018.

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[29] The population breakdown of residents who entered each home over our testwork period is as follows: Murfreesboro – 440, Humboldt – 491, Knoxville – 462, and Clarksville – 300.

[30] We originally selected a sample of 60 residents, 15 from each of the 4 homes, from a population of 2,036 residents who resided in the homes during the period January 1, 2015, through March 29, 2018. We determined during our testwork that 25 of the 60 residents selected (42%) were not in the homes long enough to require quarterly assessments and that they did not experience any significant changes during their stay to warrant significant change assessments; we excluded these residents from our sample, resulting in a sample size of 35. Due to the overall error rate of our testwork, we determined selecting and testing additional items to reach a sample size of 60 would not change our conclusion that staff did not complete assessments as required by internal policy.

[31] The population breakdown for residents who resided in each home over our testwork period is as follows: Murfreesboro – 551, Humboldt – 596, Knoxville – 586, and Clarksville – 303.

Direct Care Providers

We interviewed key personnel to obtain an understanding of how the homes contract with direct care providers and how those direct care providers bill for their services. We began an investigation into some of the direct care providers based on allegations we received. Our office will issue a separate report with the results of that investigation.

Medicine Distribution and Controls

To obtain an understanding of controls regarding medicines in the homes, we reviewed the homes' internal policies, and we interviewed appropriate personnel and performed walkthroughs of medicine distribution, shift changes, and the medicine room.

We performed an analysis of controlled substances received by the homes using records provided by the pharmacy contractor. We analyzed the records for irregularities in the number of prescriptions filled per year, the prescription count per resident, the number of prescriptions written by each physician, and the amount of a controlled substance dispensed at one time. We noted no irregularities regarding the number of prescriptions filled per year or the number of prescriptions written by each physician and determined no further work was required for those parts of the analysis. We asked the contractor about any controlled substance prescriptions because it appeared the contractor provided more than a 30-day supply, and we performed a more in-depth review of prescription counts per resident when the number of controlled substances per year exceeded 12; this condition applied to 114 residents. We obtained a reasonable explanation for the amounts dispensed by the contractor and determined no further work was needed for that part of the analysis.

We reviewed prescription orders for 45 of the 114 residents (39%) we identified for further examination, because their prescription orders were stored in the electronic medical records. We noted no issues based on this review of orders, and we determined it was not necessary to obtain and review paper files for the other 69 of 114 residents we identified because the paper files system was the older system. Because we obtained reasonable assurance that the contractor was distributing controlled substances in compliance with orders stored in the electronic records, which was the process in place for storing prescription orders at the time of our review, no further work was needed.

To determine whether the nurse on duty signed off to demonstrate distributing residents' medications as prescribed, we selected for testwork a random, nonstatistical sample of 60 residents, 15 from each of the 4 homes, from a population of 2,036 residents[32] who resided in the homes during the period January 1, 2015, through March 29, 2018. In addition, we judgmentally determined that an additional resident would be tested, bringing our total to 61 items to test. We haphazardly selected one week for each resident in the sample to test whether medicine was adequately distributed and documented, and we requested management pull three extra files in case we could not test one or more items in our initial tested sample. Based on our review, two residents we selected were discharged the day after their admission to the home, so their files did

[32] The population breakdown for residents per home is as follows: Murfreesboro – 551, Humboldt – 596, Knoxville – 586, Clarksville – 303.

not contain sufficient medicine distribution records to test. Additionally, the Director of Clinical Services was unable to provide 3 of the 64 medicine distribution files we requested (5%) because the record storage location file was lost due to some past computer issues; for our purposes, we considered these files missing. Given these circumstances, we actually tested a total of 59 residents.

Death and Injuries

To obtain an understanding of how the homes document and report resident injuries and deaths, we interviewed appropriate personnel, performed walkthroughs, and reviewed applicable guidance. From a population of 3,032 injuries[33] that occurred in the homes from January 1, 2015, through March 28, 2018, we selected a nonstatistical, random sample of 60 injuries, 15 from each home, to determine if staff adequately documented the injury and followed up based on the homes practices. From a population of 655 deaths[34] that occurred in the homes from January 1, 2015, through March 18, 2018, we selected a nonstatistical, random sample of 60 deaths, 15 from each home, to determine if the homes reported deaths as required by state rules. We also performed an analysis of deaths that occurred in the homes to identify patterns which could indicate staff did not provide proper care to residents. We did not identify any patterns requiring further review.

QUALITY CONTROL

Internal Monitoring

We interviewed appropriate personnel and reviewed policies and federal guidance to obtain an understanding of the expectations set forth for internal monitoring. We requested copies of meeting minutes for all Quality Assurance Committee and subcommittee meetings that should have occurred during our audit period (722 meetings). We obtained and reviewed all minutes available for Quality Assurance Committee and subcommittee meetings, and we asked management about the minutes the home could not locate and provide. We gathered and reviewed 61 Executive Summaries the Financial Compliance Officer prepared as part of his monitoring duties.

Complaints

We interviewed key personnel to obtain an understanding of the processes management used to receive and process complaints. We reviewed the *Code of Federal Regulations* pertaining to long-term care facilities and the requirements for receiving complaints. We also reviewed articles pertaining to the best practices for hotlines.

[33] The population breakdown of injuries per home is as follows: Murfreesboro – 973, Humboldt – 914, Knoxville – 744, and Clarksville – 401.

[34] The population breakdown of deaths per home is as follows: Murfreesboro – 170, Humboldt – 224, Knoxville – 212, Clarksville – 49.

We obtained the call logs for the CareLine and the Compliance Hotline for the period January 1, 2015, through February 5, 2018. We excluded from the lists calls that were not complaints (wrong numbers, informational calls, hang-ups), and we obtained and reviewed any files, documentation, personnel files, associated with the remaining 62 calls received and the steps management took to substantiate the complaints and implement necessary corrective actions.

Additionally, we obtained and reviewed the meeting minutes taken at the monthly resident council meetings in each of the veterans' homes for the period January 1, 2015, through March 2018 for the Murfreesboro, Humboldt, and Knoxville homes and through April 2018 for the Clarksville home to identify complaints expressed by residents during these meetings. We identified complaints noted and reviewed management's actions to address the complaints. We also obtained and reviewed Social Services Department grievance logs for each of the four homes for the period January 1, 2015, through April 2018 and for one home through May 2018).

Corrective Actions

To obtain an understanding of the surveys, we interviewed appropriate personnel. To obtain an understanding of violations that occurred in the homes and planned corrective actions, we reviewed copies of all state and federal surveys conducted on each of the homes from the Department of Health's website (apps.health.tn.gov/Facilityinspections). We also compiled copies of the results of the most recent surveys conducted by the U.S. Department of Veteran's Affairs for each home from management. From the surveys provided, we obtained and reviewed the most recent of each type of survey (Federal Recertification, State Licensure, State Life Safety, Federal Life Safety) for each home, as well as all nine surveys conducted as the result of a complaint to the Department of Health during the period January 1, 2015, through April 1, 2018.

Based on our review, we compiled a population for testwork of 24 issues noted in the surveys which required corrective action by the homes where surveyors had not yet confirmed that the homes appropriately implemented the proposed corrective action. We reviewed documentation to determine whether management of the homes had implemented their proposed corrective actions.

HUMAN RESOURCES

Staffing Plan

We met with the Director of Clinical Services and the Finance Director and discussed the process for staff scheduling, and obtained documentation supporting the process. Additionally, we inquired about federal and state regulations of staffing levels. We reviewed Title 38, Section 51.130, *Code of Federal Regulations*, and Tennessee Department of Health Rule 1200-08-.06.

Once we learned that the most stringent regulations stated that there had to be at least 2.5 hours of direct care per patient per day (PPD) and at least one Registered Nurse on duty as a supervisor, we performed testwork to determine if the homes met the regulations. We obtained data of time reported by each staff member for the period January 1, 2015, through March 31,

2018, from the ADP software system. From the 1,186 individual dates during this period, we randomly selected 15 dates for each of the 4 homes, for a total of 60 dates randomly selected.[35] We then used the data of reported time to identify direct care staff reporting time at the particular nursing home on the randomly selected date. We then calculated how many hours per patient day (PPD) of direct care was provided at that home on that date. We also calculated if a Registered Nurse was on duty at all times for each of the dates selected.

Prior Title VI Finding

We reviewed Title VI of the Civil Rights Act of 1964, the *Code of Federal Regulations*, and the U.S. Department of Justice's *Title VI Legal Manual*. We discussed with the Director of Risk Management and the Executive Assistant the process of using a self-survey that the homes use to monitor direct care provider contractors' compliance with Title VI. We studied documentation supporting this process. After learning that the homes sent the self-surveys to direct care contractors at the end of each fiscal year, we identified a population 93 self-surveys that the homes should have obtained for fiscal years 2015, 2016, and 2017, based on the amount of direct care provider contracts in effect for each of those years. We randomly and nonstatistically selected 60 self-surveys that should have been obtained.[36] We then performed testwork to determine if the homes had obtained the self-surveys or taken corrective action against any contractor who did not comply by returning a survey. To gauge the board's oversight of the process for monitoring direct care contractors for compliance with Title VI, we reviewed board minutes in which the Executive Committee approved the policy of using a self-survey to monitor contractors.

Pre-employment Screening

We reviewed *Tennessee Code Annotated*, the Tennessee Department of Health's *Standards for Nursing Homes*, and the homes' policies and risk assessment. We discussed the process for performing screenings for employees and volunteers with the Human Resource Director of the Murfreesboro home and obtained documentation of this process. We also discussed the topic of ensuring that contractors (that provide direct care to residents) conduct required screenings of their staff, and we examined language in the contracts between the homes and direct care providers. We then obtained a list of employees who were employed at the homes during the period January 1, 2015, through April 16, 2018. We separated this list into two populations—employees who began working for the homes prior to January 1, 2015 (the beginning of our scope period), for a population totaling 611; and employees who were hired during our scope period (through April 16, 2018) for a population totaling 1,320.

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[35] The Clarksville home did not accept residents until December 2015. Therefore, we only randomly selected dates for that home from December 1, 2015, through March 31, 2018—a total population of 852 individual dates. For the other three homes, the dates were randomly selected from the period January 1, 2015, through March 31, 2018.

[36] After randomly selecting 60 self-surveys, we learned that a direct care provider contractor had erroneously been left off our list of direct care providers obtained from management. Therefore, we added this contractor to our testwork sample. As this contractor should have returned a self-survey during each of the three fiscal years being tested, the total in our sample was 63, and the total population was 96.

We selected a random, nonstatistical sample of 25 new hires from each of the populations. We tested both samples to determine if the required screenings had been completed. For the sample of those hired during our scope period, we also determined if the required screenings had been conducted in a timely manner and if the homes had used their checklist for new hires (which lists the screenings to be performed) as an internal control. For both samples, we also checked the National Sex Offender database, the Tennessee Sex Offender Database, the Tennessee Department of Health's Abuse Registry, and the U.S. Health and Human Services' Office of Inspector General exclusion database to determine if any in our samples were listed on these databases. We did not find any. We also checked Tennessee state government licensure databases to determine if those in our sample maintained their required license, and we did not note any problems.

Volunteer Screening

For volunteers, we obtained a population of 35 individuals the homes listed as volunteers during the period January 1, 2015, through February 28, 2018. We selected a random, nonstatistical sample of 25 volunteers.[37] We then performed testwork to determine if the homes had performed the required screenings prior to allowing the volunteers to begin their volunteer work. We also checked the National Sex Offender database, the Tennessee Sex Offender Database, the Tennessee Department of Health's Abuse Registry, and the U.S. Health and Human Services' Office of Inspector General exclusion database to determine if any in our samples were listed on these databases. We did not find any. Additionally, we tested to determine if the homes had used their checklist for new hires (which lists the screenings to be performed) as an internal control. Moreover, we inquired of each of the four homes' Human Resource Directors about what their definition of a volunteer was, and if there was any policy about what constituted a volunteer and what the screening procedures were.

Prior Turnover Finding

To determine if management corrected the finding regarding turnover in the November 2014 performance report, we discussed the process for producing turnover reports and their use with the Finance Director. We also observed the Finance Director reperform the production of the third quarter of fiscal year 2018 using the Automatic Data Processing (ADP) software system.

Turnover Rates

We obtained the annual turnover reports for fiscal years 2016 and 2017 from the Finance Director. We then recalculated the turnover rate percentages using the amounts in the reports. We inquired as to whether there were any standards for nursing home turnover rates. We also viewed articles obtained online about turnover in the nursing home and assisted living industry.

[37] After we had selected our random sample, the Finance Director provided an additional name to our volunteer population, for a total of 36. We added this additional item to our sample for testwork.

Exit Interviews

To determine if the management conducted exit interviews of separating employees to determine the reasons for their departure and use the information to address any concerns, we discussed the exit interview process with the Director of Risk Management and the Human Resource Director at the Murfreesboro home. We obtained a blank copy of an exit interview and reviewed the Employee Handbook, which states that separating employees are expected to have a confidential exit interview. We obtained a list of everyone employed at the homes during the period January 1, 2015, through May 11, 2018. We sorted the list by employees who had separated from the homes during this period due to resigning or retiring to obtain a population of 346 separated employees. Next, we selected a random, nonstatistical sample of 25 of these employees and requested the corresponding exit interview.

RESIDENT ADMISSIONS

Admissions Eligibility

To obtain an understanding of eligibility requirements for entering the homes, the admissions process, and the wait lists, we reviewed applicable policies and state and federal guidance, interviewed appropriate personnel and management, and performed walkthroughs of the admissions process.

For admissions eligibility, we selected a random, nonstatistical sample of 60 residents, 15 residents from each of the 4 homes, from a population of 1,693 total residents[38] who entered the homes during the period January 1, 2015, through March 29, 2018.

Denied Applications

We additionally tested a random, nonstatistical sample of 60 individuals (15 from each of the 4 homes), from a population of 1,802 total potential residents[39] who were denied admission into the homes during the period January 1, 2015, through March 29, 2018.

Wait Lists

Furthermore, we analyzed the wait lists for each home to verify that management included all information in the wait lists as required by internal policy and TennCare Rules.

[38] The population breakdown of residents who entered each home over our testwork period is as follows: Murfreesboro – 440, Humboldt – 491, Knoxville – 462, and Clarksville – 300.

[39] The population breakdown of residents per home is as follows: Murfreesboro – 390; Humboldt – 35, Clarksville – 147, Knoxville – 1,230. We could not obtain complete logs from the Murfreesboro or Humboldt homes because the homes did not maintain complete denial logs. Based on discussions with management and review of federal guidance, we are not aware of any requirement to retain documentation regarding potential resident denials; for this reason, we did not report the incomplete logs as a finding or observation in this report.

GENERAL ADMINISTRATION

Comprehensive Emergency Management Plan

We obtained and reviewed the homes' most recent Comprehensive Emergency Management Plan (CEMP), which was revised January 24, 2018, and the current CMS regulations from Title 42, *Code of Federal Regulations*, Part 483, Section 73. We also obtained a document that management prepared which compares CMS regulations to the CEMP and performed our own comparison of the CMS regulations to the CEMP. We reviewed management's documentation showing that the homes performed emergency drills during the audit period.

Information Systems and Website

We documented and verified management's internal controls over its systems. Additionally, we reviewed information on the website for consistency and to ensure it reflected the homes' current operations, and we studied the contract with the company tasked with redesigning the website.

Risk Assessment

We interviewed appropriate agency personnel and documented management's process for preparing the risk assessment. We reviewed the 2016, 2017, and 2018 risk assessments, and we compared them to each other. We gathered the homes' internal risk assessment questionnaires. We also analyzed Comptroller's Office records to determine the dates management submitted the Financial Integrity Act reports.

Possible Unlawful Conduct

We discussed actual and suspected fraud, waste, abuse, and unlawful conduct with numerous management and staff, ultimately accepting three reports from management indicating possible unlawful conduct. We compared the date the incidents occurred to the dates we received notifications.

BOARD OF DIRECTORS

Member Composition

We read Section 58-7-102(b), *Tennessee Code Annotated*, to determine the statutorily required composition of the board. We then examined board minutes and reviewed a list of board members on both Tennessee Secretary of State and Tennessee State Veterans' Homes' websites to determine if there were thirteen board members and that these members included the Commissioner of the Department of Veterans' Services; the Commissioner of the Department of Finance and Administration (or the Commissioner's designee); and at least three members from each grand division of the state. We analyzed appointment letters along with documentation provided by the Governor's office to determine if at least one member met the statutory requirements to be a nursing home administrator and at least one member possessed clinical experience. We made inquiries with the Department of Veterans' Services to determine that the remaining members were veterans of a variety of branches of the United States Armed Forces as required by statute.

Conflicts of Interest

We reviewed Section 58-7-106, *Tennessee Code Annotated*, along with the board's bylaws and policy. We then performed testwork to determine if all board members had annually signed the conflict-of-interest acknowledgement statement required by board policy for fiscal years 2015, 2016, 2017, and 2018.

Quorum Standard and Meeting Attendance

We made inquiries with the Finance Director and reviewed Section 8-44-108, *Tennessee Code Annotated*, along with the board's bylaws. We then reviewed the board meeting minutes for each board meeting that took place from January 2015 through May 2018 to determine which members were in attendance at each board meeting. We performed an analysis of board member attendance to document the percentage of board meetings each board member attended during each fiscal year in our audit period.[40] We noted any board member who did not attend at least 50% of the meetings in any one of the fiscal years.

Open Meetings Requirements

We interviewed the Finance Director and the Director of Information Technology regarding public notice requirements and practices. We examined Sections 8-44-102-104 and 4-35-108, *Tennessee Code Annotated*. We performed testwork on all board meetings, Executive Committee meetings, and Audit Committee meetings held during our audit period from January 2015 through May 2018 by examining the homes' website to determine if a public notice had been posted. While we noted the date written on the public notices, we attempted but were

[40] We only tested board meetings that took place during the second half of fiscal year 2015 because our audit period began at January 1, 2015. We tested board meetings that occurred in January, March, May, and June 2015, for a total of four board meetings in fiscal year 2015.

unable to verify the dates that the notices had been posted to the website as there was a lack of documentation of these updates to the website. To determine if the Executive Director's annual review had been discussed in public, we examined the Executive Committee minutes and board meeting minutes for the four annual reviews that occurred during our audit period. We also examined the agendas for the four Executive Committee meetings to determine if the annual review was listed on the agenda.

Strategic Planning

We interviewed the Finance Director and several board members, including the chair. We examined board meeting minutes to review strategic planning. We obtained and examined the board's strategic plan for the period 2018 – 2023. We obtained and reviewed documentation of the veteran population from the Department of Veterans' Services. Finally, we viewed documentation from various sources supporting the plans to construct new homes, along with their cost and funding sources.

APPENDIX 2
Quality of Life and Quality of Care Standards Established in the *Code of Federal Regulations* (CFR)

Quality of Life Standards in 38 CFR 51.100

Federal Requirement	Requirement Description	Internal Policy
(a) *Dignity*	The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	"Dignity and Quality of Life" Policy
(b) *Self-determination and participation*	The resident has the right to— (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; (2) Interact with members of the community both inside and outside the facility; and (3) Make choices about aspects of his or her life in the facility that are significant to the resident.	"Dignity and Quality of Life" Policy
(c) *Resident Council*	The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council.	*Your Rights As a Resident of the Tennessee State Veterans' Home and Other Important Information*
(d) *Participation in resident and family groups*	(1) A resident has the right to organize and participate in resident groups in the facility; (2) A resident's family has the right to meet in the facility with the families of other residents in the facility;	*Your Rights As a Resident of the Tennessee State Veterans' Home and Other Important Information*

	(3) The facility management must provide the council and any resident or family group that exists with private space; (4) Staff or visitors may attend meetings at the group's invitation; (5) The facility management must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; (6) The facility management must listen to the views of any resident or family group, including the council established under paragraph (c) of this section, and act upon the concerns of residents, families, and the council regarding policy and operational decisions affecting resident care and life in the facility.	
(e) *Participation in other activities*	A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. The facility management must arrange for religious counseling by clergy of various faith groups.	*Your Rights As a Resident of the Tennessee State Veterans' Home and Other Important Information*
(f) *Accommodation of needs*	A resident has the right to— (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and (2) Receive notice before the resident's room or roommate in the facility is changed.	"Abuse & Neglect of Residents and Misappropriation of Residents' Property" Policy
(g) *Patient Activities*	(1) The facility management must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. (2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional.	*Your Rights As a Resident of the Tennessee State Veterans' Home and Other Important Information* "Activity" Policy "Activity Outing" Guidelines

(h) *Social Services*	(1) The facility management must provide medically related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident. (2) For each 120 beds, a nursing home must employ one or more qualified social workers who work for a total period that equals at least the work time of one full-time employee (FTE). A State home that has more or less than 120 beds must provide qualified social worker services on a proportionate basis (for example, a nursing home with 60 beds must employ one or more qualified social workers who work for a total period equaling at least one-half FTE and a nursing home with 180 beds must employ qualified social workers who work for a total period equaling at least one and one-half FTE).	"Social Services" Policy
(i) *Environment*	The facility management must provide— (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible; (2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; (3) Clean bed and bath linens that are in good condition; (4) Private closet space in each resident room, as specified in § 51.200(d)(2)(iv) of this part; (5) Adequate and comfortable lighting levels in all areas; (6) Comfortable and safe temperature levels. Facilities must maintain a temperature range of 71-81 degrees Fahrenheit; and (7) For the maintenance of comfortable sound levels.	"Abuse & Neglect of Residents and Misappropriation of Residents' Property" Policy

Quality of Care Standards in 38 CFR 51.120

Federal Requirement	Requirement Description	Internal Policy
(a) *Reporting of Sentinel Events*	A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function. . . . The facility management must report sentinel events to the director of VA [Veterans Affairs] medical center of jurisdiction within 24 hours of identification.	"Reporting of Sentinel/Adverse Events to the Veterans Administration" Policy*
(b) *Activities of daily living*	Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was	"Activities of Daily Living" Policy "Facility Nutrition Program" Policy

	unavoidable. This includes the resident's ability to—(i) Bathe, dress, and groom; (ii) Transfer and ambulate; (iii) Toilet; (iv) Eat; and (v) Talk or otherwise communicate. (2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section; and (3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.	
(c) *Vision and hearing*	To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident— (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	"Vision & Hearing" Policy
(d) *Pressure sores*	Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	"Pressure Ulcer" Policy
(e) *Urinary and Fecal Incontinence*	Based on the resident's comprehensive assessment, the facility management must ensure that— (1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (2) A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible; and (3) A resident who has persistent fecal incontinence receives appropriate treatment and services to treat reversible causes and to restore as much normal bowel function as possible.	"Bladder (and Bowel) Incontinence Assessment" Policy "Urinary Incontinence" Policy
(f) *Range of*	Based on the comprehensive assessment of a resident,	"Range of Motion" Policy

motion	the facility management must ensure that— (1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and (2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	
(g) *Mental and Psychosocial functioning*	Based on the comprehensive assessment of a resident, the facility management must ensure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem.	"Social Services" Policy
(h) *Enteral Feedings*	Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings was unavoidable; and (2) A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills.	"Activities of Daily Living" Policy "Enteral Nutrition" Policy "Enteral Nutrition" Guide
(i) *Accidents*	The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	"Accident" Policy*
(j) *Nutrition*	Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified.	"Meal Intake Percentage" Guide "Menu Alternates" Policy "Nourishment" Policy
(k) *Hydration*	The facility management must provide each resident with sufficient fluid intake to maintain proper hydration and health.	"Resident Hydration" Policy
(l) *Special needs*	The facility management must ensure that residents	"Clinical Comprehensive

	receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses.	Care Plans" Policy "Clinical Podiatry" Policy
(m) *Unnecessary drugs*	(1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above. (2) *Antipsychotic Drugs.* Based on a comprehensive assessment of a resident, the facility management must ensure that— (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	"Clinical Psychoactive Drug Reduction" Policy "Chemical Restraint" Policy
(n) *Medication Errors*	The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented.	"Medication Error" Policy

*As of May 23, 2018, staff used these policies although the board had not formally approved them.

APPENDIX 3
Centers for Medicare and Medicaid Services
Quality of Resident Care Ratings as of May 2018

Murfreesboro

Medicare.gov | Nursing Home Compare
The Official U.S. Government Site for Medicare

Print all information

Nursing home profile

Quality of resident care

TENNESSEE VETERANS HOME

Overall rating *4 out of 5 stars*
Above Average

Learn more about the overall star ratings

Quality of resident care

Nursing homes that are certified by Medicare and Medicaid regularly report clinical information for each of their residents to the Centers for Medicare & Medicaid Services (CMS). CMS assigns nursing homes a quality of resident care star rating based on their performance on 16 measures. These measures reflect, on average, how well nursing homes cares for their residents. Information is listed for 2 groups of residents:

- Short-stay residents - those who spent 100 days or less in a nursing home
- Long-stay residents - those who spent over 100 days in a nursing home

Learn more about what quality of resident care information can tell you about a nursing home

Quality of resident care	*3 out of 5 stars* Average
Short-stay residents	

Learn why these short-stay measures are important

Current data collection period

https://www.medicare.gov/nursinghomecompare/profile.html 5/18/2018

	TENNESSEE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of short-stay residents who improved in their ability to move around on their own. *Higher percentages are better.*	72.1%	66.2%	67.8%
Percentage of short-stay residents who were re-hospitalized after a nursing home admission. *Lower percentages are better.*	28.8%	20.5%	21.1%
Percentage of short-stay residents who have had an outpatient emergency department visit. *Lower percentages are better.*	15.3%	12.6%	11.9%
Percentage of short-stay residents who were successfully discharged to the community. *Higher percentages are better.*	33.1%	58.5%	57.0%
Percentage of short-stay residents who report moderate to severe pain. *Lower percentages are better.*	9.2%	11.4%	13.3%
Percentage of short-stay residents with pressure ulcers that are new or worsened. *Lower percentages are better.*	0.9%	0.6%	0.9%
Percentage of short-stay residents who needed and got a flu shot for the current flu season. *Higher percentages are better.*	95.2%	82.3%	81.5%

	TENNESSEE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of short-stay residents who needed and got a vaccine to prevent pneumonia. *Higher percentages are better.*	78.9%	84.6%	83.3%
Percentage of short-stay residents who got antipsychotic medication for the first time. *Lower percentages are better.*	1.9%	2.2%	2.0%

▼ Long-stay residents

Learn why these long-stay measures are important

Current data collection period

	TENNESSEE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents experiencing one or more falls with major injury. *Lower percentages are better.*	4.9%	3.4%	3.4%
Percentage of long-stay residents with a urinary tract infection. *Lower percentages are better.*	3.9%	4.2%	3.4%
Percentage of long-stay residents who report moderate to severe pain. *Lower percentages are better.*	5.2%	4.6%	5.6%

	TENNESSEE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay high-risk residents with pressure ulcers. *Lower percentages are better.*	5.2%	5.4%	5.6%
Percentage of long-stay low-risk residents who lose control of their bowels or bladder. *Lower percentages are better.*	47.9%	56.3%	47.9%
Percentage of long-stay residents who have or had a catheter inserted and left in their bladder. *Lower percentages are better.*	1.1%	2.0%	1.8%
Percentage of long-stay residents who were physically restrained. *Lower percentages are better.*	0.0%	0.9%	0.4%
Percentage of long-stay residents whose ability to move independently worsened. *Lower percentages are better.*	18.2%	21.4%	18.3%
Percentage of long-stay residents whose need for help with daily activities has increased. *Lower percentages are better.*	12.8%	16.0%	15.0%
Percentage of long-stay residents who lose too much weight. *Lower percentages are better.*	5.5%	7.8%	7.1%

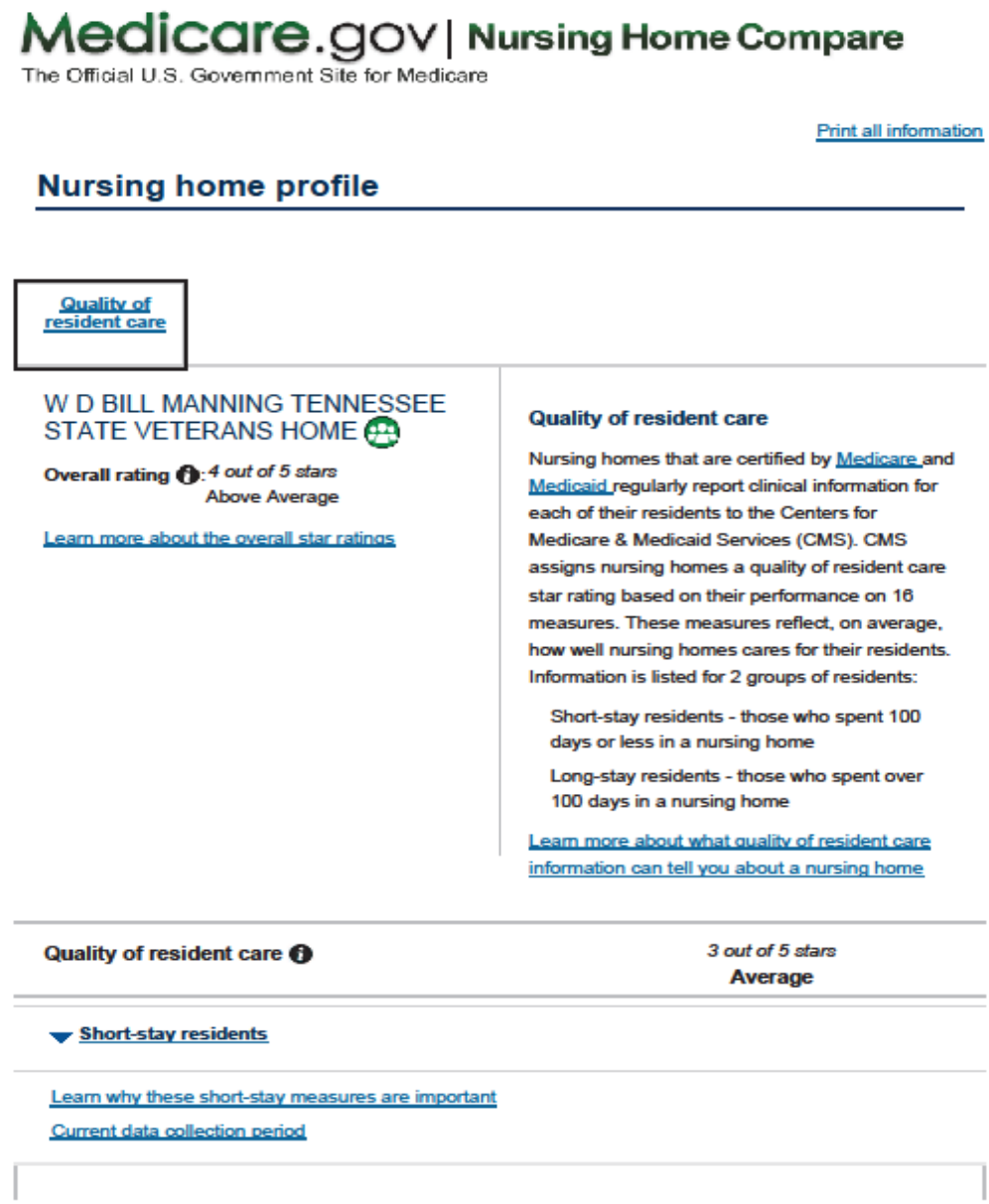
	TENNESSEE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents who have symptoms of depression. *Lower percentages are better.*	1.6%	2.0%	4.8%
Percentage of long-stay residents who got an antianxiety or hypnotic medication. *Lower percentages are better.*	23.0%	36.1%	22.4%
Percentage of long-stay residents who needed and got a flu shot for the current flu season. *Higher percentages are better.*	100.0%	93.9%	95.1%
Percentage of long-stay residents who needed and got a vaccine to prevent pneumonia. *Higher percentages are better.*	97.9%	93.0%	94.1%
Percentage of long-stay residents who got an antipsychotic medication. *Lower percentages are better.*	20.0%	16.7%	15.5%

If footnotes appear in the table, hover over the number to get more details.

Medicare.gov

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244

Humboldt



Medicare.gov | Nursing Home Compare
The Official U.S. Government Site for Medicare

Print all information

Nursing home profile

Quality of resident care

W D BILL MANNING TENNESSEE STATE VETERANS HOME

Overall rating: *4 out of 5 stars*
Above Average

Learn more about the overall star ratings

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Learn why these short-stay measures are important

Current data collection period

https://www.medicare.gov/nursinghomecompare/profile.html 5/21/2018

	W D BILL MANNING TENNESSEE STATE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of short-stay residents who improved in their ability to move around on their own. *Higher percentages are better.*	83.9%	66.2%	67.8%
Percentage of short-stay residents who were re-hospitalized after a nursing home admission. *Lower percentages are better.*	20.1%	20.5%	21.1%
Percentage of short-stay residents who have had an outpatient emergency department visit. *Lower percentages are better.*	14.5%	12.6%	11.9%
Percentage of short-stay residents who were successfully discharged to the community. *Higher percentages are better.*	31.5%	58.5%	57.0%
Percentage of short-stay residents who report moderate to severe pain. *Lower percentages are better.*	12.0%	11.4%	13.3%
Percentage of short-stay residents with pressure ulcers that are new or worsened. *Lower percentages are better.*	0.8%	0.6%	0.9%

	W D BILL MANNING TENNESSEE STATE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of short-stay residents who needed and got a flu shot for the current flu season. *Higher percentages are better.*	82.5%	82.3%	81.5%
Percentage of short-stay residents who needed and got a vaccine to prevent pneumonia. *Higher percentages are better.*	79.8%	84.6%	83.3%
Percentage of short-stay residents who got antipsychotic medication for the first time. *Lower percentages are better.*	9.9%	2.2%	2.0%

▼ Long-stay residents

Learn why these long-stay measures are important

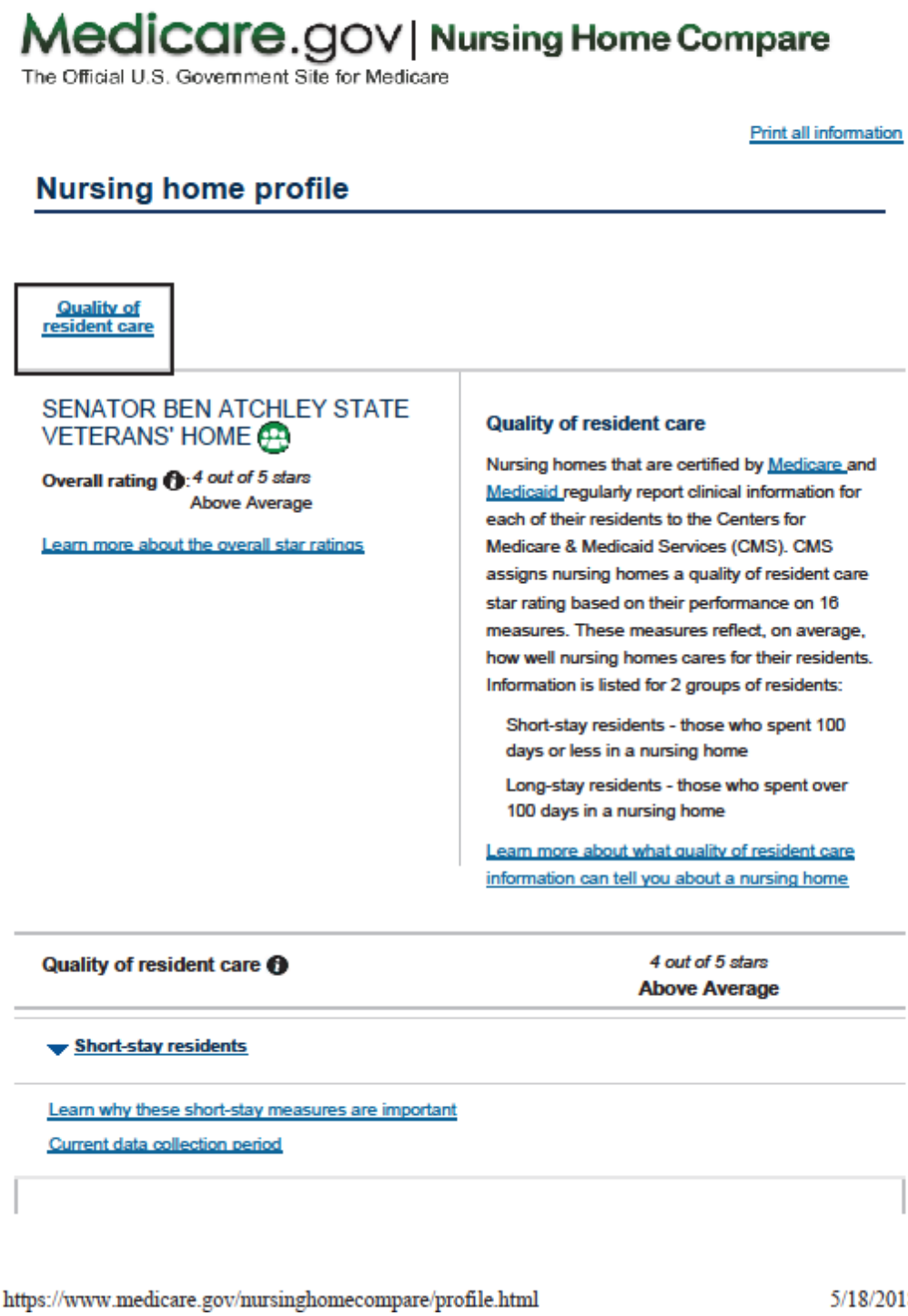
Current data collection period

	W D BILL MANNING TENNESSEE STATE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents experiencing one or more falls with major injury. *Lower percentages are better.*	2.9%	3.4%	3.4%

	W D BILL MANNING TENNESSEE STATE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents with a urinary tract infection. *Lower percentages are better.*	12.2%	4.2%	3.4%
Percentage of long-stay residents who report moderate to severe pain. *Lower percentages are better.*	9.9%	4.6%	5.6%
Percentage of long-stay high-risk residents with pressure ulcers. *Lower percentages are better.*	3.6%	5.4%	5.6%
Percentage of long-stay low-risk residents who lose control of their bowels or bladder. *Lower percentages are better.*	52.8%	56.3%	47.9%
Percentage of long-stay residents who have or had a catheter inserted and left in their bladder. *Lower percentages are better.*	1.0%	2.0%	1.8%
Percentage of long-stay residents who were physically restrained. *Lower percentages are better.*	0.0%	0.9%	0.4%
Percentage of long-stay residents whose ability to move independently worsened. *Lower percentages are better.*	11.0%	21.4%	18.3%

	W D BILL MANNING TENNESSEE STATE VETERANS HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents whose need for help with daily activities has increased. *Lower percentages are better.*	15.0%	16.0%	15.0%
Percentage of long-stay residents who lose too much weight. *Lower percentages are better.*	9.0%	7.8%	7.1%
Percentage of long-stay residents who have symptoms of depression. *Lower percentages are better.*	4.3%	2.0%	4.8%
Percentage of long-stay residents who got an antianxiety or hypnotic medication. *Lower percentages are better.*	45.5%	36.1%	22.4%
Percentage of long-stay residents who needed and got a flu shot for the current flu season. *Higher percentages are better.*	98.4%	93.9%	95.1%
Percentage of long-stay residents who needed and got a vaccine to prevent pneumonia. *Higher percentages are better.*	91.6%	93.0%	94.1%
Percentage of long-stay residents who got an antipsychotic medication. *Lower percentages are better.*	25.7%	16.7%	15.5%

Knoxville



Medicare.gov | Nursing Home Compare
The Official U.S. Government Site for Medicare

Print all information

Nursing home profile

Quality of resident care

SENATOR BEN ATCHLEY STATE VETERANS' HOME

Overall rating: *4 out of 5 stars*
Above Average

Learn more about the overall star ratings

Quality of resident care

Nursing homes that are certified by Medicare and Medicaid regularly report clinical information for each of their residents to the Centers for Medicare & Medicaid Services (CMS). CMS assigns nursing homes a quality of resident care star rating based on their performance on 16 measures. These measures reflect, on average, how well nursing homes cares for their residents. Information is listed for 2 groups of residents:

- Short-stay residents - those who spent 100 days or less in a nursing home
- Long-stay residents - those who spent over 100 days in a nursing home

Learn more about what quality of resident care information can tell you about a nursing home

Quality of resident care	*4 out of 5 stars* Above Average

Short-stay residents

Learn why these short-stay measures are important

Current data collection period

https://www.medicare.gov/nursinghomecompare/profile.html 5/18/2018

	SENATOR BEN ATCHLEY STATE VETERANS' HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of short-stay residents who improved in their ability to move around on their own. *Higher percentages are better.*	83.1%	66.2%	67.8%
Percentage of short-stay residents who were re-hospitalized after a nursing home admission. *Lower percentages are better.*	17.5%	20.5%	21.1%
Percentage of short-stay residents who have had an outpatient emergency department visit. *Lower percentages are better.*	10.7%	12.6%	11.9%
Percentage of short-stay residents who were successfully discharged to the community. *Higher percentages are better.*	31.9%	58.5%	57.0%
Percentage of short-stay residents who report moderate to severe pain. *Lower percentages are better.*	6.5%	11.4%	13.3%
Percentage of short-stay residents with pressure ulcers that are new or worsened. *Lower percentages are better.*	0.5%	0.6%	0.9%

	SENATOR BEN ATCHLEY STATE VETERANS' HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of short-stay residents who needed and got a flu shot for the current flu season. ***Higher** percentages are better.*	93.2%	82.3%	81.5%
Percentage of short-stay residents who needed and got a vaccine to prevent pneumonia. ***Higher** percentages are better.*	92.9%	84.6%	83.3%
Percentage of short-stay residents who got antipsychotic medication for the first time. ***Lower** percentages are better.*	4.1%	2.2%	2.0%

▼ Long-stay residents

Learn why these long-stay measures are important

Current data collection period

	SENATOR BEN ATCHLEY STATE VETERANS' HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents experiencing one or more falls with major injury. ***Lower** percentages are better.*	3.6%	3.4%	3.4%

	SENATOR BEN ATCHLEY STATE VETERANS' HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents with a urinary tract infection. *Lower percentages are better.*	4.0%	4.2%	3.4%
Percentage of long-stay residents who report moderate to severe pain. *Lower percentages are better.*	2.3%	4.6%	5.6%
Percentage of long-stay high-risk residents with pressure ulcers. *Lower percentages are better.*	4.8%	5.4%	5.6%
Percentage of long-stay low-risk residents who lose control of their bowels or bladder. *Lower percentages are better.*	61.7%	56.3%	47.9%
Percentage of long-stay residents who have or had a catheter inserted and left in their bladder. *Lower percentages are better.*	0.5%	2.0%	1.8%
Percentage of long-stay residents who were physically restrained. *Lower percentages are better.*	0.2%	0.9%	0.4%
Percentage of long-stay residents whose ability to move independently worsened. *Lower percentages are better.*	20.8%	21.4%	18.3%

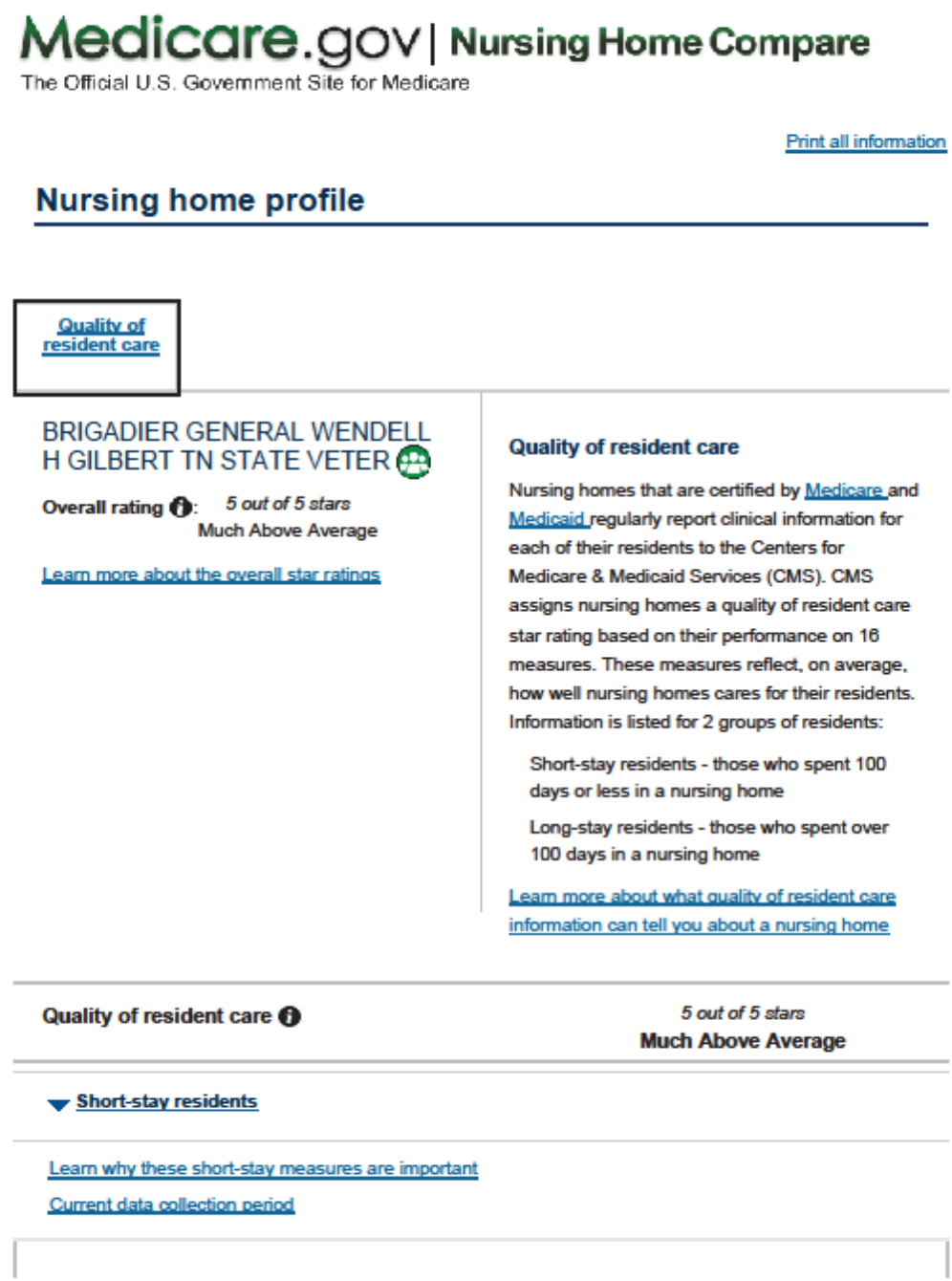
	SENATOR BEN ATCHLEY STATE VETERANS' HOME	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents whose need for help with daily activities has increased. *Lower percentages are better.*	13.3%	16.0%	15.0%
Percentage of long-stay residents who lose too much weight. *Lower percentages are better.*	11.1%	7.8%	7.1%
Percentage of long-stay residents who have symptoms of depression. *Lower percentages are better.*	5.2%	2.0%	4.8%
Percentage of long-stay residents who got an antianxiety or hypnotic medication. *Lower percentages are better.*	34.9%	36.1%	22.4%
Percentage of long-stay residents who needed and got a flu shot for the current flu season. *Higher percentages are better.*	100.0%	93.9%	95.1%
Percentage of long-stay residents who needed and got a vaccine to prevent pneumonia. *Higher percentages are better.*	100.0%	93.0%	94.1%
Percentage of long-stay residents who got an antipsychotic medication. *Lower percentages are better.*	18.2%	16.7%	15.5%

If footnotes appear in the table, hover over the number to get more details.

Medicare.gov

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore, MD 21244

Clarksville



Medicare.gov | Nursing Home Compare
The Official U.S. Government Site for Medicare

Print all information

Nursing home profile

Quality of resident care

BRIGADIER GENERAL WENDELL H GILBERT TN STATE VETER

Overall rating: 5 out of 5 stars
Much Above Average

Learn more about the overall star ratings

Quality of resident care

Nursing homes that are certified by Medicare and Medicaid regularly report clinical information for each of their residents to the Centers for Medicare & Medicaid Services (CMS). CMS assigns nursing homes a quality of resident care star rating based on their performance on 16 measures. These measures reflect, on average, how well nursing homes cares for their residents. Information is listed for 2 groups of residents:

Short-stay residents - those who spent 100 days or less in a nursing home

Long-stay residents - those who spent over 100 days in a nursing home

Learn more about what quality of resident care information can tell you about a nursing home

Quality of resident care — 5 out of 5 stars
Much Above Average

Short-stay residents

Learn why these short-stay measures are important

Current data collection period

https://www.medicare.gov/nursinghomecompare/profile.html 5/18/2018

	BRIGADIER GENERAL WENDELL H GILBERT TN STATE VETER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of short-stay residents who improved in their ability to move around on their own. *Higher percentages are better.*	82.3%	66.2%	67.8%
Percentage of short-stay residents who were re-hospitalized after a nursing home admission. *Lower percentages are better.*	NOT AVAILABLE	20.5%	21.1%
Percentage of short-stay residents who have had an outpatient emergency department visit. *Lower percentages are better.*	NOT AVAILABLE	12.6%	11.9%
Percentage of short-stay residents who were successfully discharged to the community. *Higher percentages are better.*	NOT AVAILABLE	58.5%	57.0%
Percentage of short-stay residents who report moderate to severe pain. *Lower percentages are better.*	6.7%	11.4%	13.3%
Percentage of short-stay residents with pressure ulcers that are new or worsened. *Lower percentages are better.*	0.9%	0.6%	0.9%

	BRIGADIER GENERAL WENDELL H GILBERT TN STATE VETER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of short-stay residents who needed and got a flu shot for the current flu season. ***Higher** percentages are better.*	93.0%	82.3%	81.5%
Percentage of short-stay residents who needed and got a vaccine to prevent pneumonia. ***Higher** percentages are better.*	84.4%	84.6%	83.3%
Percentage of short-stay residents who got antipsychotic medication for the first time. ***Lower** percentages are better.*	0.9%	2.2%	2.0%

▼ **Long-stay residents**

Learn why these long-stay measures are important

Current data collection period

	BRIGADIER GENERAL WENDELL H GILBERT TN STATE VETER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents experiencing one or more falls with major injury. ***Lower** percentages are better.*	3.3%	3.4%	3.4%

	BRIGADIER GENERAL WENDELL H GILBERT TN STATE VETER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents with a urinary tract infection. *Lower percentages are better.*	3.4%	4.2%	3.4%
Percentage of long-stay residents who report moderate to severe pain. *Lower percentages are better.*	2.4%	4.6%	5.6%
Percentage of long-stay high-risk residents with pressure ulcers. *Lower percentages are better.*	3.3%	5.4%	5.6%
Percentage of long-stay low-risk residents who lose control of their bowels or bladder. *Lower percentages are better.*	41.7%	56.3%	47.9%
Percentage of long-stay residents who have or had a catheter inserted and left in their bladder. *Lower percentages are better.*	1.2%	2.0%	1.8%
Percentage of long-stay residents who were physically restrained. *Lower percentages are better.*	0.0%	0.9%	0.4%
Percentage of long-stay residents whose ability to move independently worsened. *Lower percentages are better.*	14.6%	21.4%	18.3%

	BRIGADIER GENERAL WENDELL H GILBERT TN STATE VETER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of long-stay residents whose need for help with daily activities has increased. *Lower percentages are better.*	12.6%	16.0%	15.0%
Percentage of long-stay residents who lose too much weight. *Lower percentages are better.*	9.7%	7.8%	7.1%
Percentage of long-stay residents who have symptoms of depression. *Lower percentages are better.*	3.4%	2.0%	4.8%
Percentage of long-stay residents who got an antianxiety or hypnotic medication. *Lower percentages are better.*	31.4%	36.1%	22.4%
Percentage of long-stay residents who needed and got a flu shot for the current flu season. *Higher percentages are better.*	100.0%	93.9%	95.1%
Percentage of long-stay residents who needed and got a vaccine to prevent pneumonia. *Higher percentages are better.*	95.8%	93.0%	94.1%
Percentage of long-stay residents who got an antipsychotic medication. *Lower percentages are better.*	11.2%	16.7%	15.5%

If footnotes appear in the table, hover over the number to get more details.

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A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore, MD 21244

Data Collection Periods for Quality of Resident Care Ratings

Current collection dates for available Quality of resident care measures.	Current collection dates for available Quality of resident care measures.	
	From	Through
Short-stay residents		
Percentage of short-stay residents who improved in their ability to move around on their own.	1/1/2017	3/31/2018
Percentage of short-stay residents who were re-hospitalized after a nursing home admission.	10/1/2016	9/30/2017
Percentage of short-stay residents who have had an outpatient emergency department visit.	10/1/2016	9/30/2017
Percentage of short-stay residents who were successfully discharged to the community.	7/1/2016	6/30/2017
Percentage of short-stay residents who report moderate to severe pain.	1/1/2017	3/31/2018
Percentage of short-stay residents with pressure ulcers that are new or worsened.	1/1/2017	3/31/2018
Percentage of short-stay residents who needed and got a flu shot for the current flu season.	1/1/2017	3/31/2018
Percentage of short-stay residents who needed and got a vaccine to prevent pneumonia.	1/1/2017	3/31/2018

Percentage of long-stay residents who lose too much weight.	4/1/2017	3/31/2018
Percentage of long-stay residents who have symptoms of depression.	4/1/2017	3/31/2018
Percentage of long-stay residents who got an antianxiety or hypnotic medication.	4/1/2017	3/31/2018
Percentage of long-stay residents who needed and got a flu shot for the current flu season.	4/1/2017	3/31/2018
Percentage of long-stay residents who needed and got a vaccine to prevent pneumonia.	4/1/2017	3/31/2018
Percentage of long-stay residents who got an antipsychotic medication.	4/1/2017	3/31/2018
Percentage of short-stay residents who got antipsychotic medication for the first time.	1/1/2017	3/31/2018
Long-stay residents		
Percentage of long-stay residents experiencing one or more falls with major injury.	4/1/2017	3/31/2018
Percentage of long-stay residents with a urinary tract infection.	4/1/2017	3/31/2018
Percentage of long-stay residents who report moderate to severe pain.	4/1/2017	3/31/2018
Percentage of long-stay high-risk residents with pressure ulcers.	4/1/2017	3/31/2018
Percentage of long-stay low-risk residents who lose control of their bowels or bladder.	4/1/2017	3/31/2018
Percentage of long-stay residents who have or had a catheter inserted and left in their bladder.	4/1/2017	3/31/2018
Percentage of long-stay residents who were physically restrained.	4/1/2017	3/31/2018
Percentage of long-stay residents whose ability to move independently worsened.	4/1/2017	3/31/2018
Percentage of long-stay residents whose need for help with daily activities has increased.	4/1/2017	3/31/2018

Percentage of long-stay residents who lose too much weight.	4/1/2017	3/31/2018
Percentage of long-stay residents who have symptoms of depression.	4/1/2017	3/31/2018
Percentage of long-stay residents who got an antianxiety or hypnotic medication.	4/1/2017	3/31/2018
Percentage of long-stay residents who needed and got a flu shot for the current flu season.	4/1/2017	3/31/2018
Percentage of long-stay residents who needed and got a vaccine to prevent pneumonia.	4/1/2017	3/31/2018
Percentage of long-stay residents who got an antipsychotic medication.	4/1/2017	3/31/2018